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## DOCTOR OF PHILOSOPHY

### The impact and use of patient feedback in general practice

#### A realist review

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*A realist review*

Deborah Baldie

2014

University of Dundee

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**Thesis Title**

**The impact and use of patient feedback in general practice:  
A realist evaluation**

**Deborah Baldie**

**Doctor in Philosophy**

**University of Dundee**

**October 2014**



## Contents

Contents.....	3
List of Figures .....	7
List of Tables.....	8
Acknowledgements .....	9
Declaration .....	10
Abstract .....	11
Chapter 1 Introduction and Background Literature .....	13
Patient feedback as part of the health care policy about quality .....	14
Patient feedback is a complex concept .....	16
The use of patients' views about health care .....	21
A definition of formal patient feedback .....	22
The relevance of patient experience as a health outcome .....	23
Variation in experiences of general practice care .....	24
Quality assurance and governance in the medical profession .....	25
Formal patient feedback within general practice and primary care .....	27
Patient surveys .....	28
Better Together Survey .....	29
GP appraisal and revalidation .....	29
Policy assumptions about formal patient feedback .....	29
Policy informed assumptions – the evidence .....	32
Assumption 1 – There are valid ways of assessing the health care of experiences of patients for use in feedback .....	32
Assumption 2 - Feedback of information about patients' experiences to service providers (directly and/or indirectly via public reporting) stimulates improvement efforts within individuals/teams/organisations .....	33
Assumption 3 - Improvement efforts initiated by organisations, teams or individuals lead to improvements in future patients' experience of health care .....	34
Summary .....	35
Study Aims.....	36
Research questions.....	36
Chapter 2 Methods .....	38
Introduction.....	38
Methodology .....	38
Critical realism and natural science .....	39
Critical realism and social science .....	39
Realistic evaluation .....	41
Stage 1: Realist Review .....	46
Programme theory.....	47
Review strategy.....	47
Key steps .....	48
Critical Appraisal .....	49
Data Extraction .....	50
Data synthesis and programme review .....	50
Stage 2: Realistic Evaluation .....	51
Case studies.....	53

Data analysis .....	56
Methods.....	56
Introduction.....	56
Stage 1: Review .....	57
Stage 2: Evaluation using comparative case studies.....	61
Rigour and credibility .....	78
Summary .....	84
Chapter 3 Stage 1: Realist Review Findings.....	86
Introduction.....	86
Review findings .....	86
Q1 Is the use of formal patient feedback associated with changes in future patients' experiences in primary health care settings? .....	87
Q2 What appears to influence the use of formal patient feedback in primary health care teams and is validity important? .....	88
Q3 What appears to influence the effectiveness of efforts (stimulated by patient feedback) aimed at improving future patients' experiences in primary health care? .....	92
Discussion .....	93
Conclusions.....	95
Proposed CMO.....	98
Chapter 4 Summary of case study data collected and case characteristics .....	102
Introduction.....	102
Data Collected.....	102
Routine data .....	103
Documents .....	103
Staff interviews and observations – recruitment details .....	105
Number of observations.....	107
Patient interviews - recruitment details.....	107
Practice characteristics.....	109
How each practice team described themselves during recruitment .....	109
Location, size and demographics of each practice.....	110
Davidson Practice .....	112
Blair Practice.....	118
Sutherland Practice .....	126
Conclusion .....	131
Chapter 5 Stage 2: Findings (a) Gathering of formal patient feedback and deciding to act on it.....	134
Introduction.....	134
How the three practices gathered and viewed patient feedback .....	138
Assessment of the extent to which CMO is upheld in each practice. ....	141
Davidson Practice Context.....	141
Davidson Practice Mechanisms .....	144
Summary of Davidson Practice Findings .....	157
Blair Practice Context.....	161
Blair Practice Mechanisms .....	166
Summary of Blair Practice Findings.....	169
Sutherland Practice Context.....	172
Sutherland Practice Mechanisms .....	176
Summary of Sutherland Practice Findings .....	183
Summary .....	185

Chapter 6 Stage 2 Findings (b) Improvements in response to patient feedback – how they are implemented and the impact they have .....	190
Introduction.....	190
.....	1
Assessment of the extent to which the reasoning and the mechanisms 2 and 3 are upheld in three improvements in Davidson Practice .....	192
Access to appointments with preferred GP (Example 1 from previous chapter) .....	193
Getting through to the practice on the phone (Davidson example 2 from previous chapter) .....	200
Privacy at the desk (Davidson example 4 from previous chapter) .....	206
Summary .....	208
Chapter 7 Patients' experiences of the service and their preferences for providing feedback .....	215
Introduction.....	215
Awareness of formal feedback mechanisms.....	216
Davidson Practice .....	218
Blair Practice.....	218
Sutherland Practice .....	219
Quality of experience .....	219
Davidson Practice .....	221
Blair Practice.....	222
Sutherland Practice .....	223
Likelihood and preference for providing feedback.....	223
Davidson Practice .....	223
Blair Practice.....	225
Sutherland Practice .....	226
Summary .....	227
Chapter 8 Discussion and Conclusions .....	230
Introduction.....	230
Key Findings.....	230
Realist review.....	230
The role of informal patient feedback.....	235
Implications for policy .....	240
National survey purpose .....	240
National survey reports .....	240
Frequency of national reports .....	241
Engaging GPs in changing national survey .....	242
Revising the CMO .....	242
Refined CMO.....	244
Implications for Practice .....	245
Patient Participation Groups (PPGs).....	245
GPs need convincing of the added value of survey feedback.....	246
Feedback of findings to Practices .....	246
Patients' awareness of how to provide feedback .....	248
Implications for research.....	248
Limitations .....	250
Strengths .....	251
Methodological critique .....	253
Conclusion .....	258
Appendices .....	260

Appendix 1 Historical summary of the increased focus of involving patients in the evaluation of general practice care .....	260
Appendix 2 Stages of programme theory development.....	265
Appendix 3 Summary of study characteristics and outcomes .....	267
Appendix 4 Participant information sheet .....	291
Appendix 5 Staff consent form .....	294
Appendix 6 Patient recruitment poster .....	295
Appendix 7 GP staff script for approaching patients.....	296
Appendix 8 Patient Information sheet .....	297
Appendix 9 Patient consent form.....	300
Appendix 10 Staff interview topic guide .....	301
Appendix 11 Patient interview topic guide.....	303
Appendix 12 Literature Review Summary .....	305
References .....	306



## List of Figures

Figure 1 Policy informed programme theory.....	32
Figure 2 Patient feedback use in general practice as a CMO configuration.....	43
Figure 3 Initial programme theory.....	45
Figure 4 Refined programme theory .....	62
Figure 5 Proposed CMO - how feedback is assumed to lead to improvements in future patients' experiences of care .....	63
Figure 6 The case (and its relationships with others) .....	64
Figure 7 Refined programme theory .....	1
Figure 8 proposed CMO - how patient feedback leads to improvements in future patients' experiences of care .....	100
Figure 9 Age profile of each practice compared with all Scotland .....	112
Figure 10 Focus of Chapter 5 .....	136
Figure 11 Focus of chapter 6.....	191

## List of Tables

Table 1 Examples of policy/strategy assumptions made about patient feedback and involvement...	30
Table 2 Defining patient feedback in general practice as a complex service intervention .....	41
Table 3 Review questions and how they relate to testing of assumptions .....	58
Table 4 Inclusion and exclusion criteria .....	60
Table 5 Practice performance against PE7 & PE8 QOF metrics .....	66
Table 6 High level coding structure and how it maps to 3 research questions: .....	77
Table 7- Documents reviewed .....	104
Table 8 Staff recruitment figures .....	106
Table 9 Observation hours .....	107
Table 10 Number of patient interviews .....	108
Table 11 Practice characteristics .....	111
Table 12 How practices gathered and viewed patient feedback .....	140
Table 13 Patient awareness of feedback mechanisms available .....	217
Table 14 How patients' experiences (of general practice care) and preferences (for providing feedback) compare with views and beliefs of general practice staff .....	220

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## Declaration

This is to certify that that I am the author of the thesis and that, all references cited have been consulted by me. The work of which the thesis is a record has been done by me and has not been previously accepted for a higher degree.

Name – Deborah Jane Baldie

Signature-

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## **Abstract**

Patient feedback about practitioners' and practices' care is commonly used in UK general practice, sometimes by practitioner choice but often embedded in quality assurance and quality improvement programmes. Significant resources in NHS Scotland are spent gathering and reporting on patients' reported experiences of care using a national GP patient experience survey – Better Together. There is however limited reference in current health policies to strong evidence demonstrating that this is an effective strategy to stimulate improvements in practice and patients' experiences of care.

This research study used realist review of existing literature to understand the impact of patient feedback at practice and practitioner level on patients' experiences of general practice care, and realist evaluation of three general practices to understand how patient feedback is viewed and used for quality improvement in everyday general practice.

Findings from the realist review indicate that there is little or no evidence that practice or practitioner level patient feedback leads to improvements in patients' experiences of general practice care. The realist evaluation demonstrated great variance in how practice teams gather and respond to patient feedback and significant concerns about the validity of the Better Together survey. Variance in the strategies used to gather feedback and responses to it were predominantly influenced by collective staff beliefs about the quality of service they provided, their estimates of patients' views of the service and their perceptions of patients' preferences for providing feedback. While GPs mostly perceived that patients would be likely to tell someone in the practice when dissatisfied, interviews with patients indicated they had little understanding of how they could give feedback and an overall preference for doing this anonymously. One practice team was seen to initiate significant changes aimed at improving patients' experiences but their ability to demonstrate improvements in experience were limited by changes in their workforce, conflicting externally set targets and methodological limitations of current patient experience measures. Further research is

needed to understand how the findings from this study apply to general practice across Scotland and how practices can be best supported to use patient feedback to improve services.

## Chapter 1 Introduction and Background Literature

I undertook this PhD study because I was interested in the enhancement of patients' experiences of health care. Working in quality improvement in acute health care, I constantly engage with motivated personnel who are committed to excellence in care, but I see how challenging they find it to engage with quality improvement in meaningful ways. I have also seen how critical clinicians can be about quality improvement data, particularly patient experience data, and have witnessed the emotional and at times defensive responses it has provoked. Clinicians and managers often struggle to ensure patients' needs and preferences are met in an ever increasing pressured system and also frequently find it difficult to pinpoint which aspects of practice need improving from the feedback they receive. At the same time, my experience is that an increased amount of time and resources has been spent in the NHS on gathering and responding to patient feedback in the last decade, but without a systematic approach to the evaluation of the impact of such quality improvement work despite a lack of strong evidence indicating significant improvements in experiences or a reduction in complaints.

Patient feedback about their experiences of general practice care has been routinely gathered in Scotland since 2004 with general practices initially receiving payment for demonstrating that they had gathered feedback and had appropriate actions plans. In 2008 general practices received payment when patient feedback scores from a nationally conducted survey relating to access to appointments were sufficiently positive. From 2009 patient feedback about their experiences of general practice care have been gathered, independent from practices and patient survey scores have been fed back to general practice teams and publicly reported. This thesis reports on a study designed to evaluate the effectiveness of formal patient feedback in improving patients' experiences of general practice care and to explore how and why such feedback is used to inform improvements in three Scottish general practices. This chapter discusses the increased importance that has been paid to patient experience as part of wider health care policy related to quality and specifically in

the context of general practice since the 2004 GP contract, an overview of the issues associated with measuring patient feedback, the assumptions that are made within current UK health care policy about patient feedback and why it is important to critically evaluate some of these assumptions before it concludes with describing the aims of this study and why it was needed.

## **Patient feedback as part of the health care policy about quality**

Improving the quality of health care is an ongoing ambition articulated in health care strategies internationally (1, 2), reflecting the linked demands of increasing public accountability and scrutiny, and the need to contain healthcare costs. These have resulted in an increased range of quality standards, efficiency targets, continual self-evaluation and external scrutiny (1, 2). Quality in healthcare is a multifaceted concept and services are held to account and attempt to make improvements across a range of quality metrics spanning the six dimensions of quality detailed in the Institute of Medicine report, 'Crossing the Quality Chasm'; safety, effectiveness, patient-centredness, timeliness, efficiency and effectiveness (3).

Since the Bristol enquiry into the safety of heart surgery on children (4) and the publication of Crossing the Quality Chasm (3) and furthered by more recent enquiries into failures in care, patient safety and person-centredness have become more central to the quality agenda (5-8). The UK for example now has a number of national patient safety programmes whose aims are to reduce harm and improve outcomes (9-11) and UK health care policy in recent years has had an increased emphasis on the need for services to be person-centred (12-14). Responding quickly and effectively to patients' needs and involving and engaging them in their health care is recognised as core to person-centred care (5) and increasingly, listening and responding to patient feedback about their experience, preferences and expectations of health care is seen as being fundamental to achieving safe, effective and person-centred (8, 13, 15-18). There is also some evidence that there is an association between positive patient experiences and other health care outcomes.



Some studies of hospital patients have demonstrated weak associations between patient experience and patient outcomes (effectiveness or safety). However they have been limited to the analysis of aggregated data and none have been able to determine whether the relationship is causal and, if it is, the direction of causality(19). One study that has used patient level data found a weak positive association between patients' reports of their experience and their reported outcomes (effectiveness of treatment and overall health) and reported post-operative complications amongst patients who had undergone surgery for hernia repair, hip or knee replacements(19). Within this study the aspect of patient experience most strongly associated with better outcomes (effectiveness of treatment and overall health, and less post-operative complications) was communication with and trust in their doctor(19). High levels of patient satisfaction have also been associated with shorter lengths of stay, less pain and less comorbidities following hip or knee surgery(20). A recent systematic review of patient satisfaction and patient reported outcomes following enhanced recovery care pathways following hip and knee surgery has also found an association between high patient satisfaction and patient education about their condition and treatment, continuity of doctors' rounds and reduced need for analgesia(21). Meta-analysis of findings was not possible in this systematic review because of methodological shortcomings of primary studies and the use of a wide range of patient satisfaction measures and patient reported outcome measures(21).

Despite these findings it is still unclear if there is a causal relationship between patient reported experience and patient reported outcomes or in what direction that might be. Authors have postulated that it may be that positive experiences may play a part in setting expectations and thus enhancing patients' reports of their outcomes from their surgery. Equally, it could be that positive outcomes mitigate negative experiences to some extent, and thus patients might rate their overall care experience as positive(19).

Whether or not improving patient satisfaction improves other outcomes, good experience of care and satisfaction with that experience is recognised as an important outcome in its own right. As a result, the gathering of patients' feedback has grown exponentially in recent years. Regular national

or regional surveys of patients to seek patients' evaluations and/or their experiences of health care have for example been introduced in most of Europe, Australia, Canada, Hong Kong, Japan, South Korea, Mexico, New Zealand and the United States(22) and furthermore there is a plethora of guidance on how patient feedback can be sought and used to improve health care (23-26).

### ***Patient feedback is a complex concept***

Patient feedback is however a complex concept. It includes views, understanding and/or rating of **health status**(e.g. functional ability, quality of life, experiences of health condition etc. )(27). Patient reported outcomes measures (PROMs) have recently been moved from the research field where they are mainly used to test effectiveness of interventions and into health care performance frameworks. Notably, PROMs reported by patients who have had hip, knee, varicose vein and hernia surgery now constitute a core element of performance review in English hospitals (28).

Patient feedback also includes views about **health care** (expectations, preferences, attitudes, evaluations, experiences, satisfaction etc) (29). While both rating of health status and views about the experience of health care have the potential to inform service evaluation and /or how health care is delivered, it is the latter which have attracted significant attention in most recent UK health care policy (2, 29-31). Health providers in Scotland are now required through the Patients' Rights Act to use feedback from patients about their health care experience to inform their service evaluation, design and improvement(17). It is this aspect of patient feedback - "*views about health care*" - and how they are used to inform quality improvement at a general practice level that are the focus of this study. However even this single aspect includes a complex range of different phenomenon.

Wensing and Elwyn (2003) have categorised patient views in three broad categories - preferences, evaluations and reports (27). *Preferences* refer to ideas about what should occur in health care systems, *evaluations* are patients' judgements about their health experience, and *reports* are patients' observations of care processes(27). Entwistle, in her categorisation of views about health

care, included *expectations* as a fourth category. Although expectations have been described in various ways she has described them broadly as including what service users think will happen, hope will happen or think ought to happen(32). This definition overlaps with Wensing and Elwyn description of “preferences” (27). Preferences are defined by Entwistle however as the kinds of health services people would like to be available in the future(32).

While these categories are helpful in conceptualising what is meant by patient views about health care each category is itself not straightforward. There are some fundamental issues with capturing and/ or measuring “views about health care”. People may for example have complex and dynamic set of views about a range of issues influenced by many factors, some of which pertain to previous experiences and some that are influenced by a variety of social and psychological factors (32). The following is not an attempt to comprehensively discuss all methodological challenges associated with gathering patients’ views about health care but instead seeks to provide a broad overview of the main issues and complexities associated with measuring or capturing patient feedback about their experiences.

**Preferences** – While it has previously been assumed that preferences are pre-existing and can be captured to support service design that meets local needs, research has indicated that when people are asked for their preferences about service features they tend to state a preference for the type of health provision they have had previous experience of (33). One qualitative study undertaken as part of a randomised controlled trial into diabetes education has also shown that in addition to patients in each arm overwhelmingly stating a preference for the intervention they received patients’ preferences also changed over time and the basis on which preferences were made before and after receiving the intervention also changed(34). While preferences prior to experience of the service were formulated around practical issues such as being able to attend the health education course, preferences formulated after the experience focused on behavioural, educational and therapeutic considerations. These findings reflect those from much earlier studies where patients tended to

believe the treatment they had been randomised to in a randomised controlled trial was the best for them (35) and reported more positive views about services they have received than those they had not (36). Attempts to design services that reflect local preferences may often therefore support the status quo and thus perpetuate the inequalities that exist (34).

**Expectations** are believed to be important as they may affect the way people behave and how they understand and evaluate health care encounters. They may for example assist patients in their health care choices and in managing their health conditions and much patient information is aimed at establishing expectations. People's expectations may however be widely variable and some may have few or low expectations of services, particularly of services they have had little previous experience of. Some may indeed have no specific expectations while others might be well-informed or ill-informed (37). The formation of expectations may be influenced by a range of factors beyond previous experience such as information about health services from other sources, health concerns they have and their views about how capable they are to cope with their health care requirement (38). Expectations, similar to preferences, may also not be static and can be influenced by patients' previous experiences, or by changing knowledge of their condition or of the health system (39).

**Evaluations** - Attempts to elicit evaluations from patients have traditionally focused on the use of patient satisfaction surveys. Satisfaction is however thought to be linked to people's expectations and as such not necessarily a reliable measure of the quality of care delivered because expectations can vary so much as discussed above. A number of other issues have been found with patient satisfaction surveys (40) (41-43). Patient satisfaction surveys have repeatedly elicited positively skewed results even when dissatisfaction or shortcomings exist (40, 44). Patient satisfaction scores have also been shown to be significantly affected by factors such as age, race, gender and geographical location rather than only with the experience of care (45-47). Satisfaction surveys are also limited in their ability to capture representative views due to their common suboptimal participation rates. Studies have shown that traditional administration methods have led to the

underrepresentation of some patient sub groups particularly those with a language barrier, substance abuse, cognitive limitations, a psychiatric diagnosis and a sight deficiency (48).

**Reports-** In an attempt to overcome the limitations of patient satisfaction surveys, patient reports of their experiences of their care have increasingly been sought (49). People's accounts of their "experience" may include their reports of what happened and what it was like for them, as well as incorporating their interpretations, reflections and evaluations (32). People's reports can also be influenced by the people or the tool/ approach that is used to gather their feedback. In the UK the Picker patient experience surveys used in England and the Better Together Patient Experience Survey (50) in Scotland are used as standard tools to gather patients' reports of their experience. Questions focus on factors known from previous research to be of importance to patients and are worded in a way that seeks to minimise the effect of varying expectations, by asking for example 'did x happen or not?' as opposed to 'were you satisfied with x?' (51). Although this approach may have gone some way to reducing the influence of patients' previous expectations on their subsequent evaluations and ensure the inclusion of patient salient questions, they are still limited by that fact that salience has been determined by research with previous patients and thus it is possible that issues important to current patients may not be explored. Importantly both the GP and hospital surveys used in the UK include some questions worded in a way that require an evaluative response; e.g. "I felt that the doctor had all the information needed to treat me" and other responses as such these may be subject to the same limitations as patient satisfaction survey questions. In the UK significant efforts have been made to eliminate the previous barriers to participation associated with postal surveys by making surveys available in a range of languages and the provision of the option to complete the survey over the phone. There has however been little examination of how effective this has been in minimising barriers to participation in specific patient sub-groups such as those with communication difficulties, cognitive impairment, intellectual difficulties, low literacy, those from ethnic minority backgrounds and other important factors.

Patient reports can also be provided through qualitative methods such as patient stories, patient interviews, complaints and suggestions and ratings posted on doctor or health provider rating websites. While patient stories and interviews are valued for their ability to focus on what matters to the responder and can provide useful insights to service quality from patients, families and carers' perspectives(25), it is increasingly recognised that they too can marginalise many sub-groups. Patient interviews are usually conducted in the majority language and take place in social contexts that have a tendency to disable and marginalise people who do not conform to dominant norms. They also tend to use methods that require significant spoken communication skills and as such, tend to exclude those exact same people that experience particular problems accessing and using general health services(32). Designs of qualitative studies have for example paid little attention to language diversity prior to recruitment and when such sub-groups have been included, patients' preferred languages are rarely used to gain informed consent (52).

The findings from qualitative approaches to exploring patients views of health care can also be limited by the ways in which patient interviews or focus groups are conducted, e.g. by limiting the focus of questioning to issues of interest to the interviewer and potentially missing those of most importance to the interviewees(32). In addition interpretations made from patients narratives can be significantly influenced by researchers' cultural backgrounds and from their approaches to analysis and the disregard of both the context in which people live and the context in which their views were sought(53, 54).

Complaints can be helpful in identifying issues with health care provision; however they are limited by the fact that they only provide feedback from those that are dissatisfied and thus do not give a comprehensive or representative reflection of the quality of patient experience. In addition much dissatisfaction goes unreported by patients and their families and thus they are unreliable as a sole indicator of the quality of patient experience(55).

In more recent years doctor ratings sites (e.g. [www.iwantgreatcare.org](http://www.iwantgreatcare.org)) and health care feedback websites ([www.patientopinion.org.uk](http://www.patientopinion.org.uk)) have emerged and arguably have the potential to gain feedback from some of the sub groups previously excluded. A small survey conducted in 2012 on a convenience sample of 200 people in London has indicated however that similar to surveys, it is white British people with higher incomes who are most aware of such sites. They also stated an increased likelihood to use such sites to provide feedback or to support their choices of health provider than low income, non- white individuals(56). Although there appears to be a gradual increase in the number of posts being placed on such sites it is unclear as yet how and to what extent these will be used by the general population and specifically by those previously marginalised by traditional research methods, or how practitioners will react to or use such feedback.

### ***The use of patients' views about health care***

While it is recognised that all methods used to seek patients' views about health care have limitations, they may still be useful and continue to be used in numerous ways. For example they have been incorporated into public reports of comparative service performance, particularly in the United States (57, 58), and in the assessment, revalidation and teaching of professionals(59) although their use for nurse revalidation is currently under debate (60). Views about health care have also been used to inform the design of new services or to redesign existing services, and to inform and support the development and delivery of health information to other patients within interventions such as the Expert Patient Programme(61).

Patient feedback is viewed in NHS policy as a useful indicator of quality, and patient feedback programmes have been promoted as useful to monitor performance and stimulate improvements in care and services. However whether they deliver the perceived benefits remains unclear (62).

Research undertaken to examine the impact of feedback in hospitals suggests little change in the quality of patient experience beyond aspects of service provision that have been subject to separately set targets(31).

Entwistle (2006)(32) and Black and Jenkinson (2009)(28) argue that patients' experiences of health care are also important in their own right as they provide a complementary perspective to that of those who provide the service and are therefore useful in enhancing person-centred care at both an individual and population level(28). This view of patient feedback is reflected in the current efforts seen in Scotland to encourage practitioners to seek patients' preferences, concerns and views of their health status and health care at the point of care and to use this information to assist patients to become increasingly engaged in their care and treatment (17, 58).

As noted above patient feedback can mean many things, so to avoid ambiguity over terminology of the type of patient feedback that is central to this study, a definition of what is meant by 'formal patient feedback' is now provided.

## **A definition of formal patient feedback**

As highlighted above patient feedback about their health care can be used for a range of purposes. In primary care specifically, it has been used at the individual patient level to inform a patients' treatment plan, or to evaluate the outcome of a treatment intervention (28). At the individual practitioner level it has been used to evaluate and inform individual doctors' consultation and care skills (59, 63-66). Patient feedback has also been used at the service level to better understand the experiences of health and health care needs and priorities of people living with particular health conditions, to inform service improvements and health care design and provision and to formally evaluate new health care interventions, health provision or improvement initiatives (24, 28, 67).

In this thesis, patient feedback is defined as the formal feedback given by patients about their views of their general practice care. It will therefore from now on be referred to as **formal patient feedback** and includes patient satisfaction/patient experience surveys, patients' views and/or accounts and evaluations of their general practice care and/or patients' written complaints and suggestions. It is therefore distinct from the more informal comments made by patients to staff



during routine care (e.g. at the reception desk and in consultations with GPs<sup>1</sup>) and from feedback that is gained through public involvement that focuses on understanding preferences, understanding people's experiences of their health conditions, seeking views on design/redesign clinical services and from feedback used to assess the effectiveness of particular treatment plans or health care interventions.

Defining formal patient feedback in this way allows the examination of a wide range of both service prompted and patient initiated types of formal feedback. It focuses the study on investigating the types of feedback that is provided to either rate experience, raise dissatisfaction, provide praise or provide suggestions that are aimed at improving future provision of general practice care and avoids the feedback within consultations that are more likely to be focused on how the patient has responded to treatment or is coping with their condition/illness and so forth.

## **The relevance of patient experience as a health outcome**

The gathering and consideration of formal patient feedback about their care is now widely accepted in policy and health care management as essential rather than optional to achieving high quality care(3, 66, 68-72).Practitioners' interpersonal skills have been found to be critical to good clinical practice and outcomes and it is widely recognised that patients are best placed to judge this element of their competence(73, 74).

There is evidence to suggest that positive patient experiences are not only important as an outcome on their own but are also closely associated with patient safety and clinical effectivenessacross a wide range of disease areas, study designs, settings, population groups and outcome measures and with patient reported and objectively measured health outcomes,adherence to recommended medicationand treatments, preventative care such as use ofscreening services and immunisations,healthcareresource use such as hospitalisation andprimary-care visits, technical

---

<sup>1</sup> While this study did not set out to focus on informal feedback given direct to practitioners it is referred to at times in the findings and discussion chapters as it was observed as a routine source of feedback within general practice.

quality-of-care delivery and adverse events(75). Positive perceptions of GPs communication have also been associated with better recovery and better emotional health and fewer diagnostic tests and referrals(76). Poorer patient ratings of their health care experience for treatment of work related injury have also been shown to be associated with an increased risk of being off work with injury at 6 or 12 months. The risk of being off from work at 6 or 12 months was 3.54 times higher (95 percent Confidence interval (CI) =1.21 to 10.33,  $p=0.021$ ) for patients who rated their treatment experience less than excellent as compared to patients who rated their treatment experience as excellent(77).

Dissatisfaction with health care experiences on the other hand, negatively affects health seeking and healthcare behaviours. Patients who perceive they have been treated with disrespect, for example, are less likely to engage with routine secondary preventative care, health seeking behaviours or follow physicians' advice(78). Dissatisfaction is also a reliable predictor of malpractice claims, and thus has potential to increase healthcare costs(79).

## **Variation in experiences of general practice care**

Although patients in Scotland report overall positive experiences of general practice care, variation between practices and patients, especially when it comes to access, still exist(80). Much of the variance in patients' reported experiences has been reported as attributable to factors separate to the experience itself. Factors found to have the strongest effect on Scottish patients' reported experiences include patients' age and health status with older people and those in better health reporting more positive experiences (80). The size of practice has also been shown to systematically affect patients' experiences, with experiences of access and continuity being more positive in smaller practices (80). Similar factors have been found to affect patients' reported experience of general practice care in England (81, 82) and elsewhere (83, 84). Evidence from a recent English study has also highlighted that while there are differences between practices, differences also occur between patients within practices and some of this can be explained by patients' ethnicity(81).

These findings and current national survey results indicate that variances in experiences appear to exist at the practice, individual practitioner and patient levels and that despite overall relatively positive patient reports of general practice there is still scope for improvements in some patients' experiences of general practice care.

## **Quality assurance and governance in the medical profession**

Taking account of patients' views about their health care experience in reviewing, improving and designing health services have been integral to recent changes to the regulation and governance of health care. UK governments' approaches to governing the quality and effectiveness of a publicly funded NHS have changed significantly over the years. Since the medical profession's inception there has been a principal-agent problem (85, 86). Principals (patients) have had to trust doctors (agents) with their health care, while the assessment and monitoring of the doctor's expertise, conduct and performance was perceived to be beyond the "normal" person's ability (87). Consecutive UK governments have always tried to strike a balance between improvement and governance of service standards (and winning electorate votes) with distancing themselves from directly intervening in service management (86). Governance of health services (and general practice specifically) has therefore predominantly been achieved by working with professionals, particularly doctors, engaging them in strategic health care management and collegial self-governance.

It is argued that the agreements for collegial self-governance were as a result of successive governments' perceiving that principals (doctors) would be more trusted by agents (the public) than politicians to make decisions about health care provision and standards of practice (88). It is also suggested that collegial self-governance was established and continued to exist for approximately 150 years because of four key assumptions (85). First the interests of the profession and public were thought to be sufficiently aligned and therefore doctors (principals) would always act in the interests of their patients (agents). Second, non-professionals were felt to be incapable of assessing the competence of medical staff. Third, physicians were believed to be extremely virtuous and trust

worthy by merit of their codes of conduct and finally they were believed to be capable of taking action when practitioners fell short of professional standards(85). Governance arrangements have however, not been without their challenges. Successive governments have found it difficult to compel GPs to adopt or support particular policies without enhancing their contracts. It has been argued for example that most contractual changes have been in response to professionals' grievances rather than the governments' (or the public's)(88).

Universal trust in doctors has been changing over the last 3 decades and the relationship between state, profession and public has changed (89). The changes have been gradual since the eighties. Firstly there has been a "growth in public consumerism" with prioritisation of tailoring services to individuals' needs, the quality and relevance of their service outcomes for users and the importance of user involvement in need identification, service delivery and service evaluation (26, 86). The requirement to listen and use such patient feedback to inform service improvement and provide assurance now features in many regulatory and payment reward frameworks in the UK and the USA (8, 17, 62, 70, 90-92). Secondly, collegial self- governance has been weakened in the medical profession following a number of high profile medical practitioner scandals(49, 69, 72, 85). The setting of standards, monitoring practice and performance and taking action when standards are not met have increasingly been relocated outwith the profession (85).

It is suggested that such a move has been as a result of a combination of high profile medical negligence and misconduct cases and *"huge public anger, the voice permitted to a coalition of critics, shifts in social attitudes, the opportunity presented for imposing standards for accountability, and the increasing ascendancy of prointerventionist managerialist and political agendas from the early 1990s onwards"*(85). Some commentators have indicated that a move away from collegial self - governance was necessary to assure public confidence in health care (49, 85). Other have argued however that such scandals have been more about 'bad apples' and that it is important that it is recognised that it is possible to have 'bad apples' without having a 'bad orchard' (85). Dixon-Woods

(2011) commenting on an analysis undertaken by Felps et al (2006) (93) proposes that rather than the medical profession being pathogenic and growing ‘bad apples’ it has had a *“tendency to tolerate and lend protection to the inept or wicked”* and for this reason increased external regulation was and is necessary (85). Others have argued however that successive policy changes in relation to the regulation and governance of the medical profession and general practice in particular have been less about quality and public assurance and more about successive governments seeking increased control over general practice services and that this has been resisted by many (86). GPs were reported for example to resign themselves to the introduction of the new GMS contract in 2004 with its increased emphasis on performance monitoring and patient involvement in service development rather than embrace it (94). Two of the least acceptable elements of the contract to GPs were the performance monitoring systems, and greater patient involvement in service development and many GPs commented on their concerns over increased bureaucracy, control and target setting (94). There have been a number of revisions to the GP contract since 2004 and to the overall governance and regulation of general practice and practitioners. Two key pillars to the current approach to the governance and regulation of general practice and practitioners are 1) appraisal and revalidation of individual practitioners and 2) payment in accordance with achievement of clinical quality standards set within a Quality and Outcomes Framework (QOF). Both frameworks include formal patient feedback.

## **Formal patient feedback within general practice and primary care**

Although there has been a steady increase in consumerism within the NHS since the inception of the 1966 GP contract (see appendix 1 for more detail), it was not formally recognised in policy until 1983 that health care providers should consider the experiences and perceptions of patients as one way of examining how well health services were being provided(95). A subsequent plethora of policies reiterated the need to consider patients’ experiences of care followed, however implementation of such policies into general practice has been slow (96, 97).

## ***Patient surveys***

Prior to the new GMS contract in 2004, the gathering of patient feedback was voluntary and undertaken for example when practices chose to work towards practice accreditation or a practice quality award. The 2004 contract introduced for the first time, the ability for general practices to claim discretionary payments through the Quality and Outcomes' Framework (QOF) for administering approved patient experience surveys (practitioner specific or practice level) and developing relevant actions plans(98). There appears to be little examination of the extent to which UK GPs engaged with this aspect of QOF in Scotland and a recent review indicated that Scottish NHS managers were unclear, four years after its introduction, of how many general practices had participated in this aspect of QOF or the impact it had on practice(97).

In the 2006/7 review of QOF, a direct enhanced payment was established. In addition to gaining payment for conducting approved patient surveys, practices were rewarded discretionary payments for good access based on patients' responses to a nationally conducted survey(99). In 2008, reward for good access was moved into the QOF with two new patient experience indicators, Patient Experience 7 (PE7) and PE8 being introduced. This signified a move away from practice administered surveys to centrally conducted patient surveys, administered by independent parties on behalf of the government. Results from the centrally administered General Practice Patient Survey (GPPS) in England and the Scottish General Practice Access Survey were used to allocate funding based on responses to the access questions contained within each survey until PE7 and PE8 were removed in 2011/12. The shift to national surveys (first access then patient experience) was significant in that this was the first time that any element of practice funding was determined by patients' ratings of their experience. Furthermore, survey results were made publicly available rather than being held confidential within practices, or within the Board when practices have agreed to share their data with Boards.

### ***Better Together Survey***

The Better Together patient experience survey is currently administered by Healthcare Improvement Scotland on behalf of the Scottish Government and is expected to support improvements in patients' experiences of general practice by providing practices with their survey results every two years (100) Patient Experience Programme}. It seeks patients' experiences of access to appointments with health professionals; being referred to other services; reception care and practice environment; doctors' consultation skills, nurses' consultation skills; knowledge about their prescribed medicines; dignity respect and overall experience ratings(100).

### ***GP appraisal and revalidation***

In addition to practice surveys, GPs have used patient surveys within their appraisal process since its inception in 2002 in England, Northern Ireland and Scotland in 2003 and Wales in 2004 (101).

Revalidation of doctors, which commenced in 2012, also requires evidence of patient feedback via a patient survey every 5 years. There has been much debate over appraisal and revalidation. The medical profession have resisted several recommendations for radical changes to their regulation and specifically to revalidation plans by repeatedly claiming they were impractical and too costly (102). As such it has taken significant time for plans for appraisal and subsequently revalidation to be agreed (102). While revalidation is summative and used to determine a practitioner's fitness for practice, appraisal is a formative process, designed to support GPs' development. A number of surveys are approved for use within either framework. Within appraisal however, formal patient feedback from a patient survey is intended to be used along with other sources of performance evidence to support practitioners to reflect on their practice and develop relevant personal development plans (103).

### **Policy assumptions about formal patient feedback**

The expectation within the appraisal process that patient feedback has the potential to stimulate reflection and support the development of improvement plans is mirrored in the literature

associated with the Better Together patient experience survey. Here too there is an expectation that patients' experiences will be continually improved by gathering and feeding back their views and evaluations of their experience of care either publicly or privately to practitioners, teams, departments or organisations. Examples of similar expectations can be found in recent health policy and reports relating to the quality of NHS care. Some are provided in Table 1 below – see specifically for example quotes from the Health Care Quality Strategy and the Delivering Quality in Primary Care for claims on the benefits of the Better Together patient experience survey.

**Table 1 Examples of policy/strategy assumptions made about patient feedback and involvement**

**Better Health, Better Care 2007 (12)**

*“Better Together – Scotland’s new Patient Experience Programme will encourage and empower patients, carers and health care staff in Scotland to work together in partnership to provide patient centred care and improve NHS services for the benefit of all.” (page 6)*

**Darzi report (2008)(13)**

*“We will raise standards.... For the first time we will systematically measure and publish information about the quality of care from the frontline up. Measures will include patients’ own views on the success of their treatment and the quality of their experiences” (page 11)*

*“Quality of care includes quality of caring. .... It can only be improved by analysing and understanding patient satisfaction with their own experiences.” (page 47)*

**The Health Care Quality Strategy for NHS Scotland (2010)(6)**

*“Success will mean that, for the first time, people in Scotland will have the opportunity to comment systematically on their experience of healthcare and its impact on their quality of life [and] an assurance that NHS Scotland services will be further improved in the light of what people tell us about their experiences and outcomes.” (page 2)*

Interventions will include *“Action in response to the first results of the Better Together Patient Experience surveys” (page 11)*



*“We have a number of programmes... which are aimed at putting people at the centre of care and at supporting the development of relationships between NHSScotland staff, patients and carers which result in shared decision-making, better experiences and outcomes for patients and carers, and greater job satisfaction for staff” (page 25)*

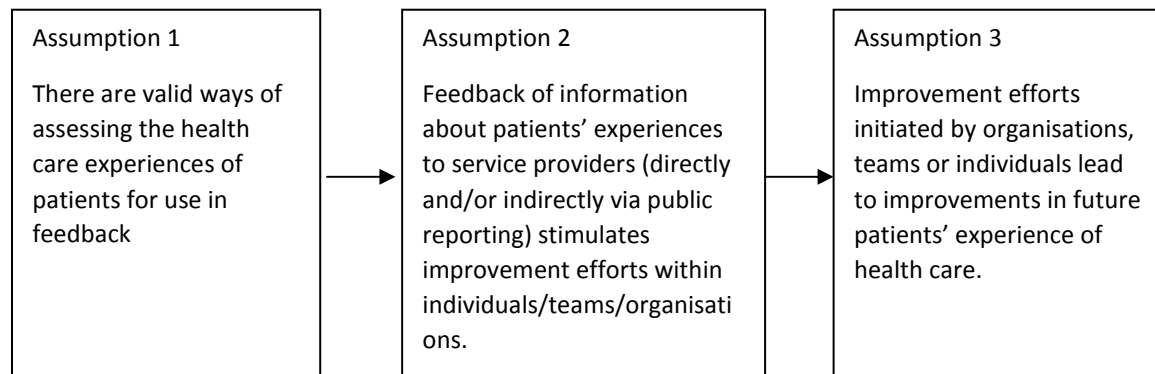
**Delivering Quality in Primary Care: National implementing the Healthcare Quality Strategy for NHSScotland (2010)(74)**

*“The national survey results as part of the Better Together patient experience programme give a picture of patients’ perception of access. It will be crucial to use these results to focus actions and give priority to helping all Primary Care contractors improve access for patients.”(74) ( page 5)*

**Commission on the future delivery of public services (2011)(104)**

*“The priorities we identified include: recognising that effective services must be designed with and for people and communities – not delivered ‘top down’ for administrative convenience” (page IX)*

These assumptions about the transformative capacity of patient feedback are however made with little reference to strong evidence substantiating the effectiveness of patient feedback in improving patient care or care experience. Furthermore, within the policy and strategy literature the complexities involved in measuring patients’ experiences of health care are largely ignored. It is assumed in current health care policy that patient feedback will be gathered, provided to service providers and this will lead to ongoing improvements in patients’ experiences of care and that ipso facto, such patient feedback will be sufficiently valid and reliable for providers to make judgements about the improvements they need to make. There is no recognition in such documents that alternative positions might exist where such feedback may be (perceived as) unreliable or invalid or that feedback may not indicate a need for improvement. Instead, current policy in the UK can be seen to make three key assumptions about patient feedback that are detailed in Figure 1 below.

**Figure 1 Policy informed programme theory**

## Policy informed assumptions – the evidence

The following examines each of these assumptions in turn to set the scene as to why this study is needed. It is brief in nature as a more detailed examination of these are presented in Chapter 3, where the findings of a realist synthesis of the literature are reported.

### ***Assumption 1 – There are valid ways of assessing the health care of experiences of patients for use in feedback***

Patients' experiences of general practice care, for use in quality improvement and quality assurance, are most commonly gathered using patient surveys. In addition to the evidence cited earlier in this chapter that patients' reports of their experiences can be significantly affected by a number of factors separate to the health care itself, there are concerns over the ability of patient satisfaction surveys to detect dissatisfaction (40, 105, 106). Patient satisfaction surveys tend to have a ceiling effect, reporting consistently high levels of patient satisfaction with GP care (105, 107) and thus their ability to detect where improvements in practice are required tends to be limited.

These two key limitations (confounding variables and ceiling effects) have contributed to a move towards the more frequent use of patient experience surveys (108) which are considered to be more suitable to informing quality improvement than satisfaction surveys (31). Rather than purely asking for patients' evaluations of care, patient experience surveys also ask people to recall if certain care processes took place and by doing so it is argued that they have a greater ability to identify variations in experiences and pinpoint specific aspects of health service that need to be addressed

(31). It is this design that has informed the patient surveys currently in use in general practice in NHS Scotland, England and Wales.

Despite its rigorous development, concerns continue to be raised about the usefulness and validity of the English GPPS survey and the methodology used to administer it(109, 110).EnglishGPs are somewhat sceptical of the value of including patient survey feedback in quality improvement efforts (94). The views of Scottish GPs towards the Better Together survey are as yet however unknown.

***Assumption 2 - Feedback of information about patients' experiences to service providers (directly and/or indirectly via public reporting) stimulates improvement efforts within individuals/teams/organisations***

Although it is assumed in policy that practitioners will readily engage with patients' feedback and initiate improvements where necessary, the evidence relating to GPs engagement with quality improvement highlights that this is not without its challenges. Engagement of general practitioners in quality improvement has been reported as being limited by their heavy workloads and the quality improvement skills within their teams(108, 111).A systematic review has also indicated that audit and feedback of clinical data alone has varying effects on professional practice and that effect sizes tend to be small (112) Formal patient feedback appears to have most effect (but still moderate) amongst trainee general practitioners and little effect on experienced general practitioners (113).Furthermore there is conflicting evidence for the effects of workplace assessment feedback to doctors (which includes formal patient feedback about their interpersonal skills) on change in doctors' practice(114).

The impact of formal patient feedback therefore appears to be uncertain. There have however to date been no systematic reviews of the effect of formal patient feedback about evaluations of care at practice or individual practitioner level. Considering the reported challenges to GPs engaging with quality improvement and negative views of some GPs towards patient surveys it is reasonable to expect that their engagement with quality improvement in response to patient feedback might be variable.

***Assumption 3 - Improvement efforts initiated by organisations, teams or individuals lead to improvements in future patients' experience of health care***

Lastly, as stated earlier, current health policy explicitly assumes that improvement efforts initiated by organisations, teams or individuals lead to improvements in future patients' experience of health care. Variations in patients' experiences continue to exist however despite publication and feedback of patients' ratings to health providers (70, 97, 115). In addition, the publication and feedback of patient survey data to practices over a decade has made no difference to overall patient experience scores of Australian general practice care (105). Similarly, evidence examining the impact of patient feedback on individual practitioners' performance indicates that feedback alone or combined with other interventions has no effect (7). Closer to home, patients' experiences of health care in England have been reported as steadily improving since the introduction of a national patient survey however improvements have been small and only occurring in patient experience domains subject to targets with associated financial incentives (31).

There is some evidence that organisations in the USA can be sensitive to published information about their quality of care of which patient feedback is one element however it is perceived that this sensitivity is more related to mortality figures than patient experience scores (70). Although patient experience ratings and other quality metrics are published in the UK, distinct differences in health service structure, general practice payment reward schemes and patient choice policies between the UK and the US makes it reasonable to expect that reporting of quality metrics that include patient evaluations in the UK may not operate and influence patients' future reported experiences in similar ways to the USA.

Methodological problems with measuring patients' experiences of health care are reported to limit the ability to detect differences in patients' experiences (59, 105, 116). In addition to a relative lack of evidence of effectiveness of formal patient feedback there is also some evidence to indicate that GPs may become discouraged about the potential to improve patient survey scores, particularly

those relating to rapid access(66). Formal patient feedback may therefore not only be limited in its ability to influence future quality of care but it may bring inherent risk.

General practices gain formal feedback from sources other than surveys, yet there appears to have been little research in general practice examining the impact of other formal patient feedback such as complaints and suggestions. In addition, until now studies that have explored formal patient feedback have mainly looked at the impact of feedback on future patients' ratings of care or examined the views or attitudes of practitioners towards formal patient feedback. There would appear to be none that have systematically examined its use in quality improvement within every day practice and the impact that staff views about feedback influence how they respond to it. There also appears to be a lack of investigation into the factors that practices have to take into account when trying to make changes in response to formal patient feedback.

## Summary

The enthusiasm for gathering and reporting patient feedback appears to be somewhat ahead of the evidence demonstrating its effectiveness as a strategy for improving patients' experiences of health care (117). Such enthusiasm comes with a price however. The cost of the Better Together GP and inpatient survey combined in 2009/10 and 2011/12 was £2.4 million(118)

There is good reason therefore to examine the extent to which data from this survey and the other formal patient feedback GPs receive informs general practice and how useful or not GPs find it. Most research studies in this area have focused on the impact of feedback on future patient experience scores or on the views of GPs and in a few cases practice or quality managers. I was unable to find any studies prior to undertaking this research that sought to explore how others in the general practice team viewed or responded to patient feedback. However a number of questions in the national Better Together Patient experience survey used in general practice at the time of this study relate to components of general practice services that are delivered or coordinated by the wider

multidisciplinary team. Such components include the ease with which people can get through to the practice on the phone, helpfulness of administrative and reception staff, cleanliness and privacy afforded in reception and waiting areas and dignity and respect shown by staff(50). Understanding how this group of staff as well as GPs respond to and do or do not use patient feedback to support improvement efforts may provide useful insights into how general practice teams might enhance patients' overall experiences and identify barriers to its use in everyday practice. This research therefore examines how general practice teams use patient feedback rather than solely focusing on GPs. It explores the effectiveness of formal patient feedback at the practitioner and practice level in improving patients' experiences of general practice care by undertaking a realist review of the literature and through a realist evaluation, seeks to understand how and why formal patient feedback is used at a practice level within three Scottish general practices.

## **Study Aims**

This study has three aims:

1. To explore how effective formal patient feedback at practice or practitioner level is in improving patients' future experiences of general practice care
2. To explore how practitioners and other general practice staff gather, perceive and respond to different forms of formal patient feedback
3. To investigate how formal patient experience feedback data are used to improve services

## **Research questions**

The specific research questions are;

1. How effective is formal patient feedback at practice and practitioner level in improving patients' future experiences of general practice care?

2. How is formal patient experience feedback currently gathered and used within general practice in Scotland?
  - a) How is formal patient experience feedback obtained and shared amongst practitioners and administrative staff?
  - b) How and why do practitioners and administrative staff respond in particular ways to patient experience feedback and what factors appear to support/hinder the use of patients experience data/feedback in quality improvement?
  - c) What strategies are individuals/teams consciously using to understand and improve patients' experiences and why?
  - d) To what extent do practitioners' estimates of the quality of their service and expectations of patients' preferences for providing feedback match patients' views and preferences?

The following chapter details the methodological approach and underpinning theory that guided this research study and details the methods used to explore the effect and use of patient feedback in general practice.

## Chapter 2 Methods

### Introduction

This chapter first introduces the methodology that guided this study into the use of patient feedback within general practice. It then goes on to describe the methods used in the 2 phases of the study.

The aims of the study are to:

1. Explore how practitioners working in general practice gain access to, perceive and respond to patients' experiences of healthcare.
2. Investigate how patients' experiences of healthcare are and can be used to improve GP services.
3. Identify the strategies/approaches that appear to be useful in stimulating changes aimed at enhancing patients' experiences of GP services.

### Methodology

The use of patient experience in general practice is conceptualised within this study as a complex service intervention whose impact is dependent upon the social world in which it is placed. This view of complex interventions is consistent with critical realism principles.

Critical realism acknowledges that scientific explanations of the world are fallible as they are shaped by the social world (119). For centuries the subjectivity and objectivity of knowledge has been debated. Critical realism accepts ontologically that the natural world has and will exist independent of our cognition of it (objectivity). It accepts however that epistemologically, our knowledge of reality is the work of humans and is only ever partial, limited by our perceptions of it (subjectivity) (120). This epistemological stance has been criticised as self-contradictory (121) however the argument against this is described simply as: "scientific knowledge or any knowledge, must be knowledge of *something*" (120). Therefore the *something* must exist before and after we perceive it. Critical realism seeks to know the "something" in reality. It recognises however that knowledge of "something" needs to be



developed methodically and carefully and the imperfections and limitations of it need to be acknowledged.

### ***Critical realism and natural science***

In critical realism, ideas, concepts, meanings and categories (transitive knowledge) are produced by humans and are as real as the intransitive - the objects of knowledge that exist independent of our perceptions of them (120). The transitive are believed to emerge from the social world but thought to have impact on the intransitive (120). The transitive are however recognised as only one element of reality existing in a stratified social reality where what is empirically observed and experienced is only a subset of the actual (events and non-events) that are generated by the real. That is, the mechanisms, forces, laws etc that have enduring properties (122).

### ***Critical realism and social science***

This study into the use of patient feedback is focused on understanding one aspect of a particular social world – general practice. Similar to natural science, critical realism in social science accepts the co-existence of a social reality, that humans can put meaning to, and that which exists that they can neither see or understand (120). Human actions are viewed as occurring in a stratified social reality within critical realism(122). That is they are understood to be operating in social systems that are an interplay between structure and agency, the individual and institution(122). The social world is therefore explained by a combination of what goes on at the macro (the system, the society etc) and the micro level (the individual), each with the capacity to influence the other.

Understanding how social programmes work requires a focus on how individuals and groups react to an intervention and to each other and on the factors that influence the shape, nature and impact of the programme as it is adopted into practice.

Critical realism is therefore a helpful methodology to use. Like other social research methodologies, humans are seen as social actors living and working in social systems within critical realism. Changes or actions within social systems are understood to be as the result of generative causation. This is

understood to be different from successive causation where x leads to y through an explanatory law or principle(122). With generative causality, mechanisms (the individuals' choices and their capacity to change, derived from the social group they belong to), influence actions taken and therefore subsequent actions and outcomes(122).

I acknowledge this theoretical position has led me to concentrate my research investigation on uncovering the underlying mechanisms and contextual features and how they influence the social processes involved in gathering, receiving and responding to patient feedback. I believe however that a concentration on these issues might be helpful in shaping future efforts to improve the use of patient feedback as it focuses on tangible issues that can potentially be modified.

Other qualitative or quantitative approaches could have been used. GP practices could have been surveyed for example, but this would have focused the study on gathering data on the distribution of views about factors or issues that were already thought to be important and potentially missing issues that may be important or significant to patients and practitioners.

Other qualitative approaches with their focus more on developing deeper understandings of social phenomena could of course have been used such as phenomenology which would have focused the investigation to developing understandings of peoples' experiences of phenomena. Critical realism allows the investigation to go beyond the use of one research method and thus allows an observation and examination of the context and mechanisms in addition to gathering the social actors' interpretations of what and why actions are or are not taken and why change does or does not occur. It is therefore a useful approach to understanding the social processes involved in the use of feedback and what influences these. From a pragmatic point of view the use of a research approach that has its roots firmly in critical realism, supports the identification of issues, complexities and considerations that can potentially be further addressed in future research, policy and practice. It was for these reasons that realistic evaluation was used to conduct this study.

## ***Realistic evaluation***

Realistic evaluation is an approach to social research grounded in critical realism. It acknowledges that the way in which social groups or individuals react to interventions is influenced by the social and material contexts they operate in. This along with the beliefs and values of both those delivering and receiving interventions all have their parts to play in how successful an intervention will be at achieving its original aims.

Realistic evaluation seeks to understand how complex interventions work by comparing how they are thought to work with how they appear to work in practice(122). It is therefore an appropriate method for this study which focuses on understanding the complexity associated with the use of patient feedback as opposed to the question “does it work?”

Within critical realism, complex service interventions are thought to have 7 defining features, (123) and Table 2 shows how these relate to the use of patient feedback within general practice.

**Table2 Defining patient feedback in general practice as a complex service intervention**

<b>Defining features of complex interventions (adapted from Pawson et al 2005)(122)</b>	<b>Features of the use of patient feedback in general practice that characterise it as a complex intervention</b>
They are theories of how one action or set of actions will bring about improved outcomes.	The use of patient feedback is assumed by policy makers to have the potential to stimulate improvement efforts and result in subsequent improvements in patients' experiences.
They are active; shaped by those involved in implementing them into practice.	Engagement with patient feedback in general practice will be influenced by those working in general practice Teams and /or other parties/policies or reward schemes affecting such teams
Complex intervention theories have a long journey before they are implemented in practice, passing through heads of policy, managers, practitioners and sometimes patients. Their success is a cumulative effect of a sequence of actions and outcomes. Understanding the integrity of the theory therefore depends on the	<p>Patient feedback within general practice is likely to be affected by other priorities within general practice.</p> <p>Feedback in all its forms is likely filtered through practice managers, practice staff and GPs and its impact will be affected by decisions made and actions taken by such parties.</p>

examination of intermediate outcomes that need to be in place if final outcomes are to be achieved. Along with this, investigations also track the flows, blockages and points of contention.	<p>Intermediate outcomes associated with responses to patient feedback may be visible within practices even when changes in patients' reports of experience are not evident.</p> <p>There may a number of issues (flows, blockages, points of contention) that stimulate or hinder practices to change practice in response to patient feedback.</p>
The implementation chains in a complex intervention are not necessarily linear and can go in reverse, influenced by the power of respective parties involved.	Patient feedback is likely to be a continuous and messy process in general practice and how practices respond to it may be influenced by a number of, as yet unknown, conditions.
Complex interventions are fragile, embedded in multiple social systems. Rarely are they equally effective in different contexts so context needs to be taken into account when investigating their impact.	<p>The use of patient feedback is likely to be influenced by context i.e. will operate differently in different GP practices. Investigation into its use requires a focus on how the specific context of each practice appears to influence views and use of patient feedback</p>
Complex interventions will be influenced and changed by those learning how to best implement change. Cross fertilisation of ideas and actions may take place. Although an intervention can be named the same thing it may look and operate different in different contexts.	How patient feedback is used is expected to vary between practices as practices learn from what they have tried previously and possibly from experiences of others.
Complex interventions are open systems that change the context within which they are implemented. Learning occurs which subsequently influences how receptive people are to it in the future, which then changes its likelihood of success at achieving its desired outcome.	It is expected that individual's and practices' willingness to pay attention to patient feedback has been and can be influenced by the views and values of those working in practices and by their previous experiences of patient feedback.

Adapted from Pawson et al (2005)(122)

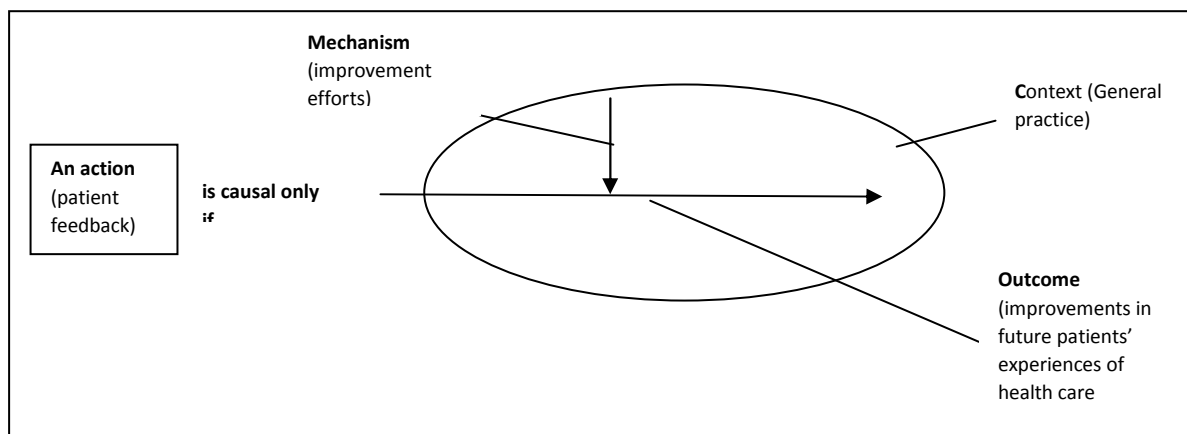
A key tenet of realistic evaluation is the development and critical analysis of context, mechanism and outcome (CMO) equations or configurations. They are often expressed as an equation(122):

$$\text{Context} + \text{Mechanism} = \text{Outcome}$$

CMO equations or configurations seek to explain how the outcome(s) (O) of actions are influenced by the reasoning and decisions (mechanisms -M) made by those the intervention is aimed at and the context (C) in which the intervention is placed. They are from now on referred to as CMO(s).

Figure 2 depicts the use of patient feedback as a CMO. Current policy makes an overarching assumption that patient feedback has a transformative capacity that will ensure future patients' experiences are improved. However, when viewing patient feedback use within general practice as a CMO, then the achievement of the intended policy outcome (improved patient experiences) is recognised as being dependent on the context and mechanisms surrounding such feedback. Within this study improved patient experience (O) is seen as being dependent on practice staff reactions to patient feedback and such reactions and subsequent reasoning, decisions and actions (M) can be affected by the context (C) they work in, their previous experience or their knowledge of the experiences of others who have received and/or used patient feedback (C).

**Figure 2 Patient feedback use in general practice as a CMO configuration**



Adapted from Figure- Generative causation (122)(p58)

Within realistic evaluation, programme theories are a way of explaining how a whole programme is thought to operate. Programme theories are viewed as schemata that demonstrate the underlying assumptions or expectations about how a complex intervention works(122). They attempt to explain the generative mechanisms that lead to the outcome. Pawson and Tilley (1997) (122)make distinctions between this and successionist causation explanations. Successionist causation looks for variables or correlates which associate one event with another. Mechanisms in realistic evaluation are responsible for the relationship. They are a process of weaving reasoning and resources. They are the “account of the make-up, behaviour, and interrelationships of those processes which are responsible for the regularity[outcome]” (122)(page 68).

For the purpose of this research the above CMO was further developed into an initial programme theory (see Figure 3 below). This initial programme theory was first introduced in Chapter 1, page 23. It was developed from an analysis of current UK health policy, strategy, reports and GMS contracts. Pawson and Tilley (1997) (122)provide little guidance on how to develop de novotheory in the absence of a clearly stated prior theory. In the absence of a specific theory on how patient feedback should operate or specific guidance on how to develop a programme theory,Iundertook a focused analysis of health policy documents from 1998<sup>2</sup> to 2012 which was informed by narrative policy analysis principles(124). Prior et al (124) highlight the benefits of concept mapping when undertaking narrative policy analysis. For the purpose of developing a programme theory about a specific intervention advocated in a broader health policy context my approach focused on the manual identification of any text relating to the following concepts –*how patient experiences should be gathered or used and theexpectations of the use or impact/benefit of the inclusion of patient experiences in health care quality improvement*. Text related to these was then highlighted and summaries of this were placed in a word table.

These summaries were then further shortened to descriptive titles and placed on flip chart paperin an attempt to develop a programme theory that reflected the “official expectations” associated with the

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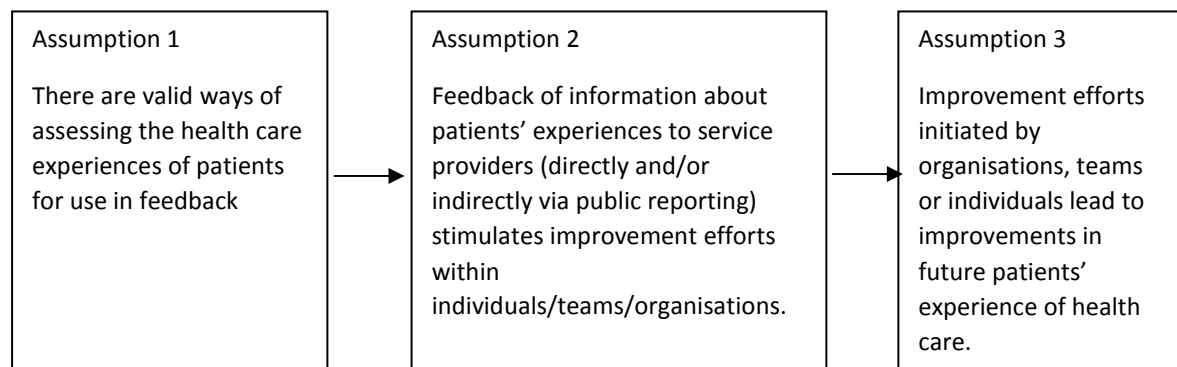
<sup>2</sup> Quality and Outcomes Framework (QOF) was introduced in 2004.however policy decisions prior to its introduction were also examined in an attempt to understand the implicit or explicit assumptions that led to the introduction of patient surveys as part of the QOF.

use of patient feedback. In addition to this, papers (identified at the scoping stage of the realist review) that detailed the use and/or impact of patient feedback in a variety of settings were examined to identify how patient feedback was presumed to work and how it was found to work, with key text relating to the concepts detailed above being highlighted and then summarised into descriptive titles before adding these to the emergent programme theory. A number of iterations were made to this as I attempted to develop a model that explained how feedback is expected to influence quality of care and are experience. Examples of the iterations can be found in Appendix 2.

Reflection on this process highlighted that the assumptions by policy makers and researchers and findings from studies within a wide range of settings were all confounded in these initial attempts at developing an explanatory model. I therefore broke the analysis into stages. I presented the programme theory as a reflection of the “official expectations” made by policy makers (which may or may not have drawn on findings from previous studies). These “official expectations” could then be adjudicated using evidence about how it has been seen to work from both a realist review of previous studies that examined the use of patient feedback specifically in the field of general practice and further by the realist evaluation of patient feedback use in 3 case study sites in Scotland.

This programme theory highlights my interpretations of 3 key assumptions implicit within recent published health care policy (see Table 1, pages 21-22 for details). In addition to the overarching assumption within policy that patient feedback will lead to improved patient experience, assumptions are made about how this could or should happen.

**Figure 3 Initial programme theory**



Within current policy and strategy it is assumed that patient experience feedback is something that can be gathered in reliable and valid ways. It is further assumed that when feedback is fed back to service providers it will stimulate improvement efforts, and lastly, that implementation of these improvement efforts will impact positively on future patients' experiences.

In order to determine the applicability of the programme theory, two specific methods were used within a broad realistic evaluation framework: The first stage helped to refine the theory in light of reports of previous empirical studies and the second sought to evaluate how closely the refined theory related to what actually happens in practice.

### *Stage 1*

Realist review of the programme theory to understand what is already known about the use of patient feedback within general practice and developed a more contextualised understanding of how it might work in practice.

### *Stage 2*

Realistic evaluation using comparative case studies to gather empirical data of how patient feedback is being used currently within general practice. This supports the use of empirical data to refine the programme theory and associated CMO.

Realist review and realistic evaluation are now described prior to providing details on how both were applied within this research study.

## **Stage 1: Realist Review**

Realist review provides a method for examining the empirical literature that seeks an explanatory rather than a judgemental outcome (122). That is, it seeks something different to a traditional systematic literature review – does x work? It instead focuses on exploring why x does or does not work in context a or b? It thus supports the inductive development of theories and/or the testing of current assumptions/theories of how interventions are thought or supposed to work(125).



### ***Programme theory***

The realist review starts with a focus on articulating how an intervention is thought to work, spelling out the assumptions that are held about the intervention. This is referred to as a programme theory. The integrity of the programme theory is then questioned and further refined in light of existing evidence (125).

### ***Review strategy***

Four possible strategies to refining a programme theory through realist review have been proposed. These include: (i) reviewing for programme theory integrity; (ii) reviewing to adjudicate between rival programme theories; (iii) reviewing the same theory in comparative settings; and (iv) reviewing official expectations against actual practice (125).

The last strategy is used within this study for 2 reasons. Firstly I could not find rival theories to be adjudicated between and secondly, the focus of the study is to understand how the theory operates in one particular setting – general practice. This strategy (iv) provided the opportunity to focus the review on how feedback has worked in general practice before going on to use data from case studies to refine the policy informed programme theory.

Regardless of the strategy chosen, there are several fundamental steps within the review process. Firstly the scope of the study needs to be articulated. It is acknowledged that because realist reviews may open a whole range of avenues of enquiry, and resources and time frames are finite, the reality is that such reviews have to be contained in some way if a comprehensive review is not feasible (126, 127). The narrowing of focus can happen at different stages such as commissioning, when the volume and nature of literature is better understood or when the questions needing to be answered become more refined as the researcher becomes more familiar with the body of evidence (126). Within this review the focus was to compare “official expectations” of how patient feedback is meant to improve patients’ experiences of general practice “against actual practice” with “actual practice” being examined through reports of studies reporting the use or impact of patient feedback (125). Early in the

review process, evidence of impact and use of patient feedback was examined in a wide range of settings such as hospitals, nursing homes, veteran facilities and ambulatory settings and educational programmes. As stated earlier an initial attempt to refine the initial programme theory by mapping how feedback worked in a variety of settings was “tested” using literature identified at the initial scoping stage of the review, but it was clear very early on that there were three key issues. Firstly, initial scoping of this literature identified significant heterogeneity in settings, outcome measures and study designs making synthesis problematic. Secondly, undertaking such a comprehensive literature reviews proved to be impossible in the time available. Lastly, a “test” of refining the programme theory (see Appendix 2 for example of the “test”) in light of the literature retrieved through the initial scanning of literature into the use of feedback in a wide variety of settings led to the development of many possible programme theories. All of the factors were associated with context and therefore to include all of this literature was viewed at this point to be counterproductive to refining a programme theory that sought to explain how feedback operated in one particular setting- general practice. In accordance with the recommendations made by Pawson et al (2005) (125), Rycroft Malone et al (2012)(127) and Wong et al (2013) (126) it was decided to refine the review at this point to focus on the impact and use of patient feedback *specifically* in general practice but not to restrict this to UK general practice. In this way the widest range of contextual features within and around general practice teams with the potential to influence the mechanisms triggered by feedback could be considered in the review.

### **Key steps**

Following clarification of the scope of a review key steps are undertaken to refine the programme theory. These include: an exploratory background search to “get a feel for the literature”; progressive focusing to identify key programme theories; refinement of inclusion criteria in light of emerging data with additional snowball sampling to explore new hypotheses and; a final review of the literature to find if there are any studies that alter any refinements of the programme theory.

## **Critical Appraisal**

Once relevant papers are retrieved their relevance and rigour are appraised prior to extracting data (123). Traditional systematic reviews based on randomised controlled trials (RCTs) rely on the removal of studies judged to have a high risk of bias based on methodological grounds. The appraisal of studies within this type of review differs however, particularly because few studies evaluating the outcomes of complex programmes are RCTs. Realist reviews permit the inclusion of different types of evidence such as quantitative, qualitative and mixed method research as well as quality improvement reports (127). While there are well established critical appraisal tools to judge the quality of quantitative research much debate exists on how to best judge qualitative research studies and if concepts such as validity and reliability used in appraising quantitative research are transferable to qualitative studies(128). Some authors consider that it is impossible to set standards for qualitative research and that by doing so creativity is stifled(129) and that the exclusion of studies rated as

*“ “low quality” because of methodological flaws or lack of reporting may ... generate new insights, grounded in the data, while methodological sound studies may suffer from poor interpretation of data, leading to an insufficient insight into the phenomenon under study”(129).*

Others continue to call for more rigorous use and reporting of analytical procedures and highlight the importance of quality assessment being based on theory and how it relates to the design of the research and the analysis and interpretation of the data(128, 130). Various checklists have been developed to critically appraise qualitative research however they have been found to be no more successful than “expert intuitive judgement” in achieving agreement amongst reviewers(131, 132). Some form of critical appraisal is required however if useful evidence syntheses of qualitative or mixed method studies are to be produced (128). Edwards et al (2000) have however developed a “signal to call” approach where a balance is sought between methodological rigour and relevance of findings as opposed to a checklist approach(132). This therefore may be a more helpful approach than the use of a

variety of checklists as this becomes less useful as the number of appraisal checklists increase in any one synthesis(123, 133).

It is therefore advocated that to ensure that quality of studies is taken into account in realist reviews, the focus of appraisal needs to shift to rigour (did the study address the theory under investigation?) and relevance (does what the researchers infer have sufficient weight to make a credible contribution to the testing of a programme theory?)(123). Appraisal therefore seeks to understand the flaws and strengths in all types of studies and make them explicit. Unlike systematic reviews of RCTs however, the degree of rigour and relevance do not influence the inclusion or exclusion of evidence from the synthesis. Instead they are used to decide if the evidence is fit for the purpose of the synthesis and to influence the weighting applied to it when included in the synthesis (123).

Each paper included in this realist review was therefore appraised based on rigour and relevance.

Judgements of each study are reported in the data extraction table in Appendix 3. Furthermore limitations of studies were considered when decisions were being made as to the “weight” studies had in influencing the refinement of the initial policy informed programme theory.

### ***Data Extraction***

The data extracted, as with other types of review, includes context, intervention type and findings. In addition, within this type of review, specific attention is paid to other data such as the specific nature of the intervention, the way in which it was implemented, the specific details of the context along with proposals about why interventions are viewed by research participants and/or researchers as successful or otherwise at that particular time point.

### ***Data synthesis and programme review***

The data extracted is then synthesised by looking for synergy and contradictions across and within studies, and constantly comparing data with the initial programme theory. This process is one in which the reviewer is constantly looking for examples from the evidence that support or refute the current assumptions held about the intervention. This process is completed by a last scan of the literature prior

to a refinement of the programme theory that provides details as to the contextual and mechanism related factors that affect the success of the intervention. In other words, it provides a much more contextualised theory that takes account of circumstances that need to be operating in particular directions if the intervention  $x$  is to result in certain mechanisms that lead to outcome  $y$ .

## **Stage 2: Realistic Evaluation**

As noted above (page 31), realistic evaluation rejects successive models of causality. That is, it does not always expect  $y$  (outcome) to occur after  $x$  (intervention) has been turned on. It instead proposes a generative causation model to understand the social and natural world. The focus of an evaluation from this perspective is gaining a better understanding of what seems to work for who and in what circumstances, in what respects and how (122). Gaining an understanding of this is achieved through developing and refining the CMO through constant comparison of the empirical evidence.

Developing an understanding of how an intervention works therefore requires the testing of CMOs (119) and an acknowledgement that the path from intervention to outcome is shaped by chains of reasoning and subsequent actions that can alter the shape, nature and impact of a complex intervention(122). An example of a CMO in this study would be:

“Teams who are:

- resourced to provide good patient experiences(C);
- view patient experiences as a key quality outcome (C);
- have access to timely patient feedback data that are presented in easily understood ways that meet GP preferences(C);

are likely to attempt to make improvements to patients’ experiences of care (M) in response to feedback and achieve improvements in future patients’ experiences (O) when they:

- collectively believe patient feedback is valid (M- reasoning)
- believe that experiences need to be improved (M-reasoning) and
- understand and believe that the feedback they gather will only be used for improvement and not external judgement (M-reasoning).
- agree to make improvements (M- reasoning)
- acknowledge that patient feedback is consistent with what staff already see as improvement priorities (M-reasoning)
- find a strategic fit between organisational priorities and patient feedback informed improvement priorities (M-reasoning)
- perceive the changes to be relatively non- complex (M-reasoning)
- implement non-complex change using tight management controls (M- action)
- Use tight management controls to make non-complex changes and access external facilitation (M- action)
- Find ways to sustain changes in practice (M- action)

Seeking to explore the chains of reasoning – the mechanisms, during an intervention and testing the extent to which a proposed CMO holds true in different contexts, exploring explanations of why responses to feedback are similar or different in different contexts is core to evaluation research (122).

## **Case studies**

Evaluation research uses a range of data including quantitative and qualitative to test and refine CMOs.

How general practices gather and act on patient feedback takes place as people go about their daily work routines. Some of it can be captured through the review of documents that capture discussions and decisions taken; some of it can only be understood by verbally seeking the views of those involved in gathering, acting on or providing feedback and some can only be understood through observing what happens in day-to-day practice.

The comparative case study method therefore provides an appropriate method for answering my research questions. Its focus is on the case and understanding the complexities within each case and provides a method through which a wide variety of data can be gathered. Comparative case studies explore the “descriptive particulars” (122) of each case, provide rich data that can be used to understand how a complex programme such as patient feedback use in general practice works in one setting and compares that with how it operates in others.

Use of such comparisons supports, through the continual testing and refinement of CMOs, the development of broader explanations of the circumstances (context and mechanisms) that affect the outcome of an intervention and therefore the refinement of programme theories. In evaluation terms this process of moving between individual characteristics of one case to broader explanations is referred to as “realistic cumulation” (122).

Case studies provide rich data however it is acknowledged that they are limited in their ability to produce generalisable findings. The strength of case studies for evaluation research instead lies in their ability to facilitate the development of meaningful, contextualised understandings and explanations of how an intervention works in different settings and the identification of particular issues that need to be taken into account in future attempts to enhance the outcome of the intervention. All explanations are, as with all theories open to further refinements as more becomes known about the complex intervention and how it is influenced by mechanisms and contexts.

### ***Structuring case studies***

Developing an understanding of the conditions (context and mechanisms) and how they influence how a complex intervention is embedded into practice is recognised as difficult to get at from the outside(122).

The purpose of this research study was to understand how and why and in what circumstances patient feedback influenced practitioners working in general practice. Although the research was guided by realistic evaluation one of the limitations of this method is that it focuses mainly on the use of quantitative data and interviewing of stakeholders to explore how those who have engaged with the intervention see their social world, and to uncover their understandings of what, how and why mechanisms have or have not been ‘fired’ by the intervention. As such, it largely ignores observational methods as a way of developing an understanding of the world to explore CMO configurations. Furthermore, while Pawson and Tilley (122) highlight that context matters and that such context (i.e. social reality) is stratified, they provide little advice on how these realities can be “got at” or explored. Unpicking the social realities that exist in organisations can be greatly helped by conceptual frameworks (134). However, the use of such frameworks can cause difficulties in realist evaluation as they are complex and causal entities in themselves. They thus make it difficult to disentangle and describe findings in conjunction with the CMO configurations that seek to explain relationships between an organisation’s context and how that relates to mechanisms fired in response to interventions that realist evaluation requires(135). It was therefore decided that a broader framework that was not focused on typology of organisations would be used. In this way all explanations as to how the context affected mechanisms and outcomes offered/observed during the process of data collection and analysis could be equally explored.

Schein’s organisational model (136) was chosen as it is partially reflective of some of the key tenets of critical realism that underpin realist evaluation. It focuses for example on the construction of the social world and the existence of multiple social realities that are thought to shape behaviours and outcomes. Schein’s model suggests that there are three specific levels within organisations where cultural



phenomena are observable - “artifacts(sic) (sic)”, “espoused values” and “shared basic assumptions”(136). Unlike other models (see for example the competing values model (137))however, Schein’s modelrefrains from classifying organisational culture or predicting how behaviours might influence outcomes. It instead offers the three levels as lenses through which an organisation can be understoodand is therefore widely regarded as a useful tool to use to examine the social context in which people work(138). Schein also indicates that examination of the three levels can be best achieved through a wide range of methods that go beyond quantitative data analysis and stakeholder interviews predominantly referred to by Pawson and Tilley(122). It therefore supports the use of observation as a useful method of data collection that permits an intimateengagement with how people worked in general practice and thus allowed me as the researcher the freedom to discover and trace the complex and emergent connections that are features of social life as it is “really” lived (139). It is also argued that “being there” in the everyday opens up the ability to contribute practically and theoretically to understandings of organisations and how they working in ways that more formal or traditional data collection methods such as documentary analysis and interviews do not(140). Schein’s three levels at which different cultural (context) phenomena are visible to observers include “artifacts(sic)”, “espoused values” and “shared basic assumptions”. The following details how these levels were applied in this data collection strategy used in this study:

Artifacts(sic) include any tangible, overt or verbally identifiable elements in an organisation.

Architecture, furniture, dress code, office jokes, all exemplify organisational artifacts(sic). Artifacts(sic) are the visible elements in a culture and they can be recognized by people not part of the culture.Espoused values are the organisation's stated values and rules of behaviour. It is how the members represent the organisation both to themselves and to others.Shared Basic Assumptions are the deeply embedded, taken-for-granted behaviours which are usually unconscious, but constitute the essence of culture. These assumptions are typically so well integrated in the organisation’s dynamic that they are hard to recognise from within.

## ***Data analysis***

Data analysis within evaluation consists of constantly comparing all forms of data gathered within and between cases and using that to test the integrity of proposed CMO(s). This process is ultimately used to refine the prevailing programme theory or propose alternatives.

Synthesising various sources of data has also been referred to as triangulation(141, 142). Synthesis through constant comparison of data is a recognised way of enhancing the credibility of qualitative interpretations and can be helpful in illuminating or nullifying some extraneous influences such as the viewpoint from which observations and assumptions are made within qualitative research(141).

Triangulation is seen as a process by which an “attempt is made to get a true fix” on a situation by combining different ways of looking at it or different findings(142). Silverman (2000) does however caution against the use of triangulation as a mechanism to resolve validity questions(142). In fact he goes as far to say that a *true fix* is an unachievable and undesirable outcome of all research(142).

Particularly in social research, realities can be represented in different ways. Notwithstanding, it is important that practitioners and policy makers have confidence in the quality of research (133).

There are numerous and sometimes confusing and contradictory criteria for assessing the quality of qualitative research (128, 133). It is therefore inappropriate and impossible to try and address all of them. Rather it is more helpful to accept that the job of the researcher(s) is to take all steps possible to ensure the design, conduct and report on research is undertaken in transparent ways such that judgements on the validity of their findings can be made by others(142). Detailed descriptions of the methods used within this study are now provided to demonstrate such transparency.

## **Methods**

### ***Introduction***

The methods section of this chapter describes how the review and evaluation stages were conducted within this study.

### ***Stage 1: Review***

Having developed an initial programme theory (Figure 3, page 35), the integrity of the programme theory was questioned and refined by undertaking a review that sought to compare the programme theory with the empirical evidence available. The review therefore focused on the retrieval and synthesis of the empirical evidence relating to the use and impact of patient feedback within primary care settings

### ***Aims***

The overall aim of the review was to critically examine the policy informed programme theory described in Figure 4 of how patient feedback is expected to improve patients' experiences of GP care using the empirical evidence. Specifically it sought to test the validity of the overarching assumption within the programme theory by searching for evidence that confirmed or refuted that patient feedback does result in changes in future patients' experiences in general practice. It then focused on examining what influenced the likelihood that the three assumptions would be realised. With assumption 1, the focus was on exploring what evidence there was to substantiate the assumption that there are valid ways of assessing patients' experiences of primary care and what appears to influence primary care personnel's perceptions of validity. The focus in assumption 2 was to examine if improvement efforts had been recognised as an interim outcome of patient feedback; the extent to which validity of patient experience data is influential in stimulating improvement efforts and to identify other factors that appear to be influential in stimulating improvement efforts. Lastly evidence was sought to explore what influenced the likelihood of assumption 3 being realised. The focus here was on identifying the factors that influenced the effectiveness of improvement efforts made by individuals, teams or organisations. These aims are summarised into 3 review questions in Table 3 below.

**Table 3 Review questions and how they relate to testing of assumptions**

Assumptions being tested	Review questions
Overarching assumption – (patient feedback in general practice leads to improvements in patient experience)	Is the use of formal patient feedback associated with changes in future patients' experiences in primary health care settings?
<b>Assumption 1:</b> There are valid ways of assessing the health care experiences of patients for use in feedback  <b>Assumption 2:</b> Feedback of information about patients' experiences to service providers (directly and/or indirectly via public reporting) stimulates improvement efforts within individuals/teams/organisations	What appears to influence the use of formal patient feedback in primary health care teams and is validity important?
<b>Assumption 3:</b> Improvement efforts initiated by organisations, teams or individuals lead to improvements in future patients' experience of health care.	What appears to influence the effectiveness of efforts (stimulated by patient feedback) aimed at improving future patients' experiences in primary health care?

### *Exploratory background search*

In order to find relevant evidence to test the programme theory an initial scan of the literature was undertaken to become familiar with the subject area. This included both an electronic search of the evidence within Medline, Cinahl and Psycinfo and a manual search of the Scottish Health Management Library.

Scanning helped identify key terms used within this field and the key journals in which such studies were published. It also highlighted the vast amount of studies and commentaries relating to the impact and/or use of feedback across a whole range of settings.

### *Progressive focusing through refinement of inclusion criteria in light of emerging data.*

In order to maintain the focus of the review the following search strategy was developed:

### The Search

#1 patient evaluation\$ OR patient feedback OR patient N2feedback OR patient satisfaction OR patient N2 satisfaction OR patient rating\$ OR patient N2 rating\$ OR patient survey OR patient N2 survey OR patient view\$ OR patient N2 view\$ OR patient prefer\$ OR patient N2 prefer OR patient complaint\$ OR patient OR patient experience\$ OR patient N2experience\$

#2 (MM "Quality IndicatORs, Health Care") OR (MM "Total Quality Management") OR (MM "Quality Assurance, Health Care") OR (MM "Management Quality Circles") OR (MM "Health Care Quality, Access, and Evaluation") OR (MM "Quality of Health Care")

#1 and #2

This search was conducted in Cochrane, MEDLINE, Psycinfo and CINAHL databases and I

searched reference lists contained within included papers and undertook hand searches of 2 key journals: Health Expectations and Quality and Safety in Health Care.

### Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were defined to ensure that the papers retrieved were focused on the review questions and had data that would support the critical review of the programme theory. These are detailed in Table 4below.

**Table 4 Inclusion and exclusion criteria**

<p>Inclusion and Exclusion Criteria</p> <p><b>Inclusion criteria</b></p> <ol style="list-style-type: none"> <li>1. Studies (systematic reviews, research studies or quality improvement reports) that examined how patient feedback to primary health care teams about their experiences of using the service has been used</li> <li>2. Studies (systematic reviews, research studies or quality improvement reports) that examined the impact of patient feedback within primary health care services</li> </ol> <p><b>Exclusion criteria</b></p> <ol style="list-style-type: none"> <li>1. Studies about patients' experiences of ill health that do not include feedback about the person's or population's experiences of using the health service. e.g. papers about lived experience of living with specific conditions</li> <li>2. Studies where it cannot be clearly ascertained if patient feedback was shared with health care staff</li> <li>3. Studies that focus on the patients' experiences of a particular treatment or intervention</li> <li>4. Methodological papers that only discuss the development of measures of patient experience or satisfaction</li> <li>5. Studies of the impact of quality reports which include a range of quality measures, one of which is patient experience scores</li> <li>6. Studies that focus on the use of patient feedback within medical education including post graduate training e.g. GP registrar training</li> <li>7. Studies that focus on patient reported outcomes measures (PROMs)</li> <li>8. Discussion papers or editorials about how health care providers have used patient feedback and /or the impact of such feedback</li> </ol>
--

### Applying the search strategy

Databases were searched by me. Screening of all titles and abstracts was also undertaken by me, with Bruce Guthrie (BG) and Vikki Entwistle (VE) (previous lead supervisor) each checking a sample of 100. Full papers were independently assessed against the inclusion and exclusion criteria by DB, VE and BG and disagreements were resolved by discussion. Characteristics of included studies and their key findings were extracted into a structured data extraction form. This can be found in appendix 3.

### Data extraction

I extracted data from all included papers relating to: outcomes measured; impact; characteristics of interventions (feedback tools used , method of feedback); the context (including country, setting, target audience etc) in which interventions were placed; and key circumstances reported by research participants and/or researchers as having affected the use of patient feedback or its impact.

### *Quality Appraisal*

Rigour and relevance were applied as the important quality criteria to each study and used to consider the relative weightings given to findings from each study when data was being synthesised.

Specifically, how relevant and important findings were thought to be, influenced the part they could play in refining the programme theory of how patient feedback has or can influence future patients' experiences. Accounts of strengths and limitations of individual studies are woven into the findings, discussion and conclusion sections of the review findings chapter.

### *Data analysis*

In the data extraction form (appendix 3) studies that treated measures of patients' experiences as outcomes of a feedback intervention were analysed to determine if the use of patient feedback is associated with changes in future patient experience (review question1). Findings from all papers were then reviewed against the programme theory. This part of the analysis sought to identify issues within and across studies that appeared to influence the gathering and use of feedback (review question 2);the determinants of improvement efforts being made in response to feedback and the subsequent influence of quality improvement efforts stimulated by such feedback (review question 3).

## ***Stage 2: Evaluation using comparative case studies***

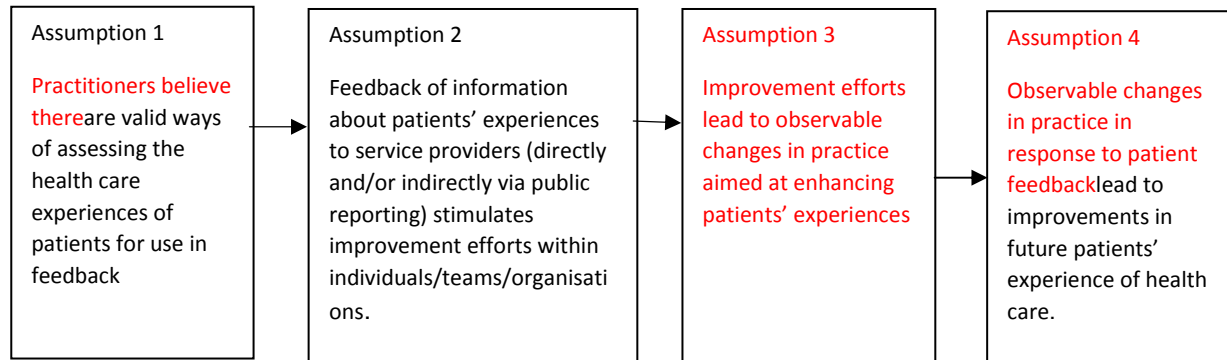
### *Introduction*

Detailed findings of the review can be found in chapter 3. These findings were used to refine the programme theory prior to it being further reviewed against data collected within the evaluation phase of the study. The refined programme theory produced by the realist review is described in more detail

in chapter 3, but is outlined here in Figure 4 since it framed the design of the comparative case studies.

Changes made to the initial programme theory are detailed here in red typeface.




**Figure 4 Refined programme theory**



This refined programme theory is further explained in a proposed CMO with three generative mechanisms - deciding to make improvements, using tight management controls to make non-complex changes and sustaining changes in practice. These mechanisms are assumed to exist and only lead to improvements in future patients' experiences when certain reasoning takes place and adequate resources exist and are thus influenced by the wider context in which they occur. The CMO is discussed in detail in Chapter 3, but also introduced here (Figure 5) to orientate the reader to the focus of Stage 2 of the research.



**Figure 5 Proposed CMO - how feedback is assumed to lead to improvements in future patients' experiences of care**

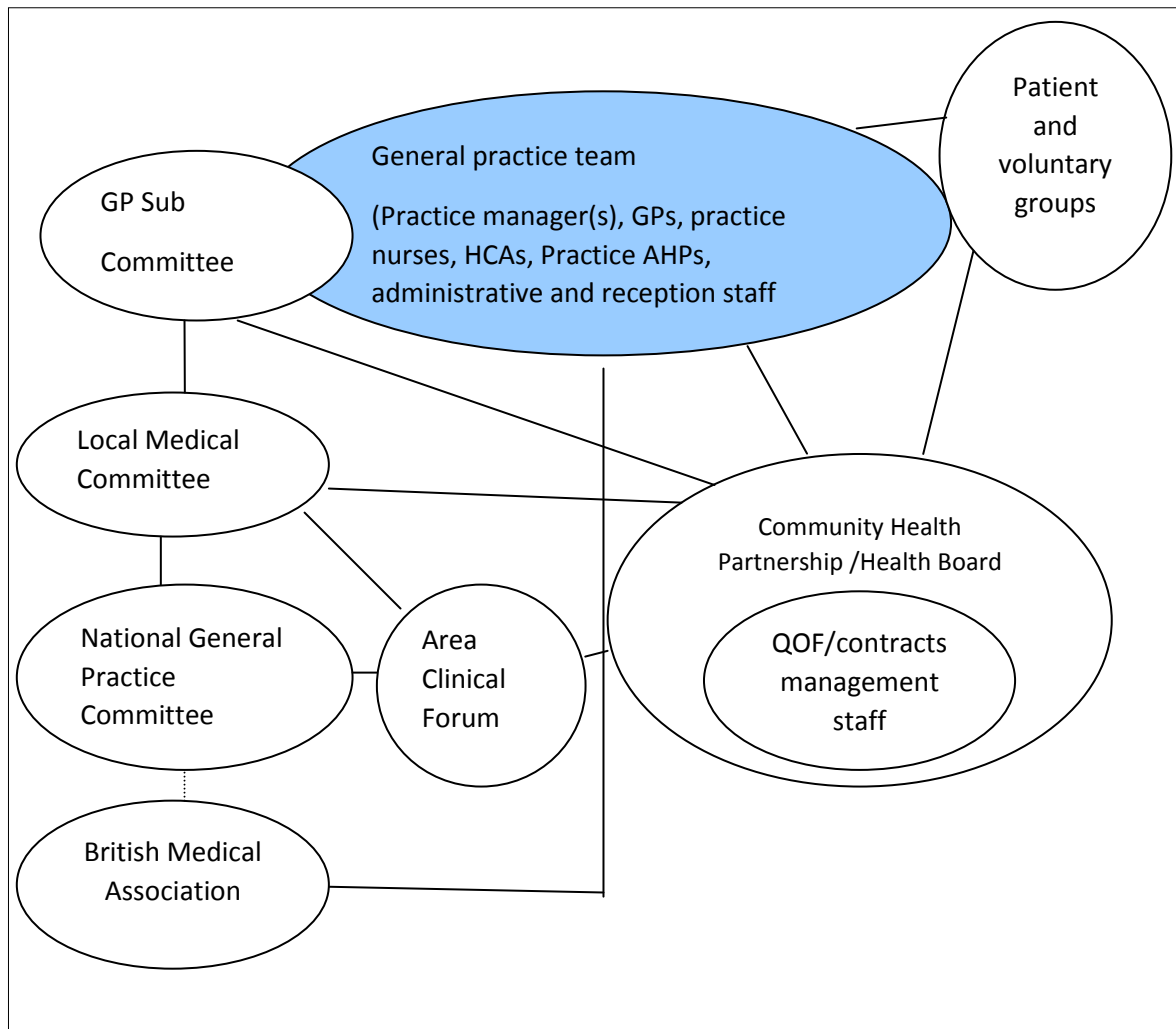
Context +	Mechanism(s) =	Outcome
<b>Practices:</b> <ul style="list-style-type: none"> <li>are resourced to provide good patient experiences</li> <li>view patient experiences as a key quality outcome and</li> <li>have access to timely patient feedback data</li> <li>are structured in ways that supports improvements to be readily implemented</li> <li>have access to data that are capable of detecting small changes in patient experience</li> </ul>	<b>Stage 1 Reasoning 1 :</b> When faced with patient feedback, teams collectively believe: <ul style="list-style-type: none"> <li>patient feedback is valid</li> <li>that experiences need to be improved</li> <li>that feedback is for improvement and not external judgement</li> <li>data are presented in easily understood ways that meet GP preferences</li> </ul>	Changes in practice are detected in future patient feedback scores
	<b>Mechanism 1</b> Team decide to try and make improvements	
	 <b>Stage 2 Reasoning</b> Teams: <ul style="list-style-type: none"> <li>acknowledge that patient feedback is consistent with what staff already see as improvement priorities</li> <li>find a strategic fit between organisational priorities and patient feedback informed improvement priorities</li> <li>perceive the changes to be relatively non-complex</li> </ul>	
	 <b>Mechanism 2</b> Team use tight management controls to make non-complex changes and access external facilitation	
	 <b>Mechanism3</b> Team find ways to sustain changes in practice	

The CMO detailed above, although informed by the literature review and policy is tentative in nature. It proposes how *it is assumed* patient feedback will impact on future patient experiences. A realistic evaluation using the comparative case study method provides the opportunity to further examine and therefore understand this process of patient feedback use and compare what happens in practice with current *assumptions*. Three cases were included in the comparative case study phase of this evaluation.

### *Units of analysis*

The unit of analysis was the general practice and all clinical and administrative/reception staff who worked within it. Practices work however within a larger network a range of organisations and agencies that all have the potential to influence the views and activities within each practice. An example of such networks and how they relate to the case is depicted in Figure 6.

### **Figure 6 The case (and its relationships with others)**



Case studies were designed to take such networks into account. Lines of enquiry outwith the practice would be followed when data within each case indicated that this was necessary and /or helpful. Such lines of enquiry were however never pursued as case study data clearly and consistently, across all three cases, indicated that decisions and actions taken did not appear to be significantly influenced by any issues or agencies outwith the practice. It is acknowledged nonetheless that opinions, views and subsequent action/inaction within practices could have been influenced by factors outwith each practice. However because it was not mentioned by staff or noticed within the data it was assumed that the impact on behaviours and actions within practices had likely been minimal. Additionally, if factors outside the practice had been impacting on decision, actions and/or attitudes to patient feedback within the practice it was assumed that it was likely to be relatively unconscious to practice staff and therefore difficult, if not impossible to investigate. A pragmatic approach to focusing only within the practices themselves was therefore taken in each case.

### *Case sampling strategy*

Case identification within this study was purposive and theoretically guided by the following 3 questions:

1. “Can I find and recruit a case that appears to readily make use of patient experience feedback?” and
2. “Can I find and recruit a case that appears to make little use of patient experience feedback?”
3. “Can I find and recruit a case that is similar (in terms of patient experience feedback use) to one of the two identified above but operates within a different wider context i.e. Community Health Partnership?”

I planned to identify cases that met these criteria by using 2 patient experience measures within the Quality and Outcomes Framework for General practice – PE 7 and PE8. PE7 scores are taken from responses to the national patient survey and measures the proportion of patients who are able to get an appointment with their practice within 48 hours of calling. PE8 identifies the proportion of patients who are able to book an appointment in advance.

Responses from patients to these questions about access to GP practices are not necessarily representative of the extent to which a practice is making use of patient experience feedback.

Nevertheless practices that scored above their CHP average on these indicators were viewed as being likely to be more responsive to patients’ needs and could have altered booking arrangements and opening hours in response to previous patient feedback about access issues from patients.

### *Recruitment of cases*

An analysis of PE7 & PE8 scores was undertaken and the results are shown in Table 5 below.

**Table 5 Practice performance against PE7 & PE8 QOF metrics**

Performance metric	Number of Practices		
	CHP1	CHP2	CHP3

Both indicators above CHP average	0	0	3
Both indicators below CHP average	1	0	1
Both indicators above Board average	0	0	3
Both indicators below Board average	1	1	1

A lack of discrimination between scores in 2 CHPs (1 and 2) was noted therefore recruitment was attempted originally in CHP 3 where differences from the average scores on PE7 and 8 were evident. Recruitment from within this CHP via 2 letters and 3 phone calls to practice managers in each practice was unsuccessful. A different strategy was therefore employed. Local informants i.e. primary care managers and clinical directors from all 3 CHPs were asked to suggest practices that met the inclusion criteria i.e. cases that appear to readily make use of patient experience feedback and those that did not. In addition I attended a regional practice manager meeting to present and seek participation in the study

All of the practices identified were contacted firstly by letter and secondly by phone until 3 cases that met inclusion criteria were recruited. The practice characteristics will be described in more detail in the findings chapters. It is important to note here however that purposive sampling ensured that practices were both similar and different to each other in a number of ways.

### *Participant recruitment – staff*

Each case study aimed to interview everyone working in professional and administrative/reception roles within the practice and to conduct observations of practice outwith clinical consultations. It was therefore necessary to ensure all staff knew of the study and that their written consent was obtained prior to undertaking any field work.

I initially informed practice staff about the study at a time convenient to the practice. All were asked to consent to observations of them in the practice and to being interviewed. Participant Information

leaflets and consent forms (see appendices 3 and 4) were left in a folder along with my details in order that staff had the opportunity to ask any further questions that had not been addressed by either the information sessions or the leaflet. All practice staff were assured that their contributions and observations of them would be confidential and anonymised. Individuals were only interviewed or observed after their written consent (appendix 5) was obtained.

Additionally, prior to arranging or undertaking any interviews I discussed the study with each participant and sought verbal confirmation of their previous written consent.

### *Participant recruitment – patients*

Because this realist evaluation was about understanding the process of use of patient feedback in general practices it was important to interview patients who had provided feedback to the practice. Interviews were to focus on seeking patients' experiences and expectations of how such feedback would be used or responded to by their practice, to consider how their perceptions and expectations matched those of general practice staff and to explore what patients' experiences of giving feedback illuminated about the practices' attitudes to and processes for gaining feedback and responding to it. Initially, it was planned that 3-5 patients who had provided the practice with some feedback in the past year would be interviewed. There had been no complaints or formal suggestions recorded in one practice (Blair Practice) in the 2 years previous to the study. The focus of interviews therefore had to change to explore patients' expectations of how their practice should gather their feedback about their experiences of the practice; to explore how patients conceptualised giving feedback to their practice, to explore the ways that patients liked to provide feedback, and (where possible) explore their experiences of providing feedback to their practice. A significant amendment to change the recruitment strategy for patients was therefore submitted to and approved by the local NHS Research Ethics Committee. This allowed for the recruitment of patients who were adults above the age of 16, who had attended for an appointment in the practice during the week previous to the recruitment period and did not lack cognition or the ability to take part in an interview conducted in English.

Posters (appendix 6) were placed in each practice waiting room inviting patients to take part. Ethical requirements prevent the sharing of patients' data with researchers prior to the person's informed consent. Reception staff were therefore asked to contact patients about the study and seek their permission to be contacted by me with a view to taking part in an interview. In an attempt to avoid selection bias by staff, practices were asked to select every 4<sup>th</sup> patient on their booking system from the week previous to them phoning the patient. They were then asked to ensure that each selected patient met the inclusion criteria prior to calling them. Staff were provided with a standard script (appendix 7) to follow when calling patients and were asked to provide me with a list of patients and their preferred contact details.

It was estimated that approximately 1/3 to a half of those agreeing to be contacted would go on to agree and then take part in an interview. Staff were therefore initially asked to identify 10 patients who agreed to be contacted in the first instance and only to identify more patients if a minimum of 3 patients per practice did not take part in an interview.

Once provided with patients' names I contacted them using their preferred contact method. I provided a verbal description of the study prior to seeking their involvement in the study. A written participant information leaflet (appendix 8) was also sent to their home prior to meeting with them to take their consent (appendix 9) and conduct an interview. Interviews were arranged to take place at a time and place convenient to the patient.

### *Data collection*

In accordance with Schein's organisational analysis framework case study data collection and analysis was organised in the following way.

#### *Artifacts(sic) - Documents*

I sought to examine a range of documents within each practice namely:

- Minutes of quality, staff and business meetings
- Minutes of meetings with patients/public

- QOF reports /performance reports
- Communication between general practice and CHP or others e.g. primary care management team regarding QOF and GP contract
- Waiting room leaflets and posters
- Patient feedback tools
- Patient feedback results, reports and action plans
- Service quality reports
- Complaints /suggestions/ thank you cards/letters
- Patient practice leaflets
- Staff protocols and training materials (where they were available)

Documents were examined to gain an insight into the context of each practice and are therefore discussed in chapter 4 - Summary of practice characteristics and data collected. Specifically, they were used to gain an understanding of how each practice worked, the ways and places in which decisions about how the practice runs are made and the extent to which feedback about or attempts to improve patients' experiences featured in the day-to-day business of the practice in comparison to other aspects of practice. Such information is detailed in the descriptions given of each case in chapter 4 - Summary of practice characteristics and data collected.

Specific documents, where they were available, were examined to gain an insight into how the practice dealt with feedback that had been received or gathered prior to the case study fieldwork and therefore my presence. These included complaints and complaint responses, Significant Event Analysis reports and practice staff agendas and minutes. Information on the processes and decisions made in relation to patient feedback was searched for within these documents. For example, I specifically looked for information on how the practice had gathered patient feedback; what types of feedback they had received; what happened when the practice received feedback; how feedback was communicated to practice staff; if it did or did not lead to improvement efforts or talk of improvement efforts; evidence of factors that the practice discussed when deciding if or what action was needed, any changes in



practice that were initiated in response to patient feedback and any notes of changes in reports of patient experiences. Data from these specific documents are therefore detailed where appropriate within the chapters 5 and 6 that examine the collection, provision, use and impact of patient feedback.

It was acknowledged that while documents are helping in building a picture of each case they often tell an “official story” and only record part of what happens in practice. Another layer of understanding of the practice and how they viewed and used patient feedback was therefore gained by interviewing staff and seeking their views and accounts of the use and impact of patient feedback.

### *Espoused Values - Staff Interviews*

To capture espoused values of individuals working in the practice semi-structured based on a topic guide were conducted with staff. They focused on seeking views and reports of feedback gathering and use and its perceived impact within general practice. Interviews were focused on respondents’ views and perceptions of:

- The range of ways in which the practice gathers the experiences of patients
- The ways in which staff in the practice get to hear about patients experiences
- The factors that influenced the practice to consider gathering and /or responding to patient feedback
- The changes that staff believe have been put in place in response to patient experience data
- The processes/conditions that staff believe have facilitated their ability to be responsive to patients feedback about their service
- The factors that have inhibited staff to act on feedback from patients about their service
- How the gathering and use of feedback can best support improvement of services in the future  
i.e. what do they think would work in their practice and why?

There were core questions asked of all, however staff interviews were also iterative in that they sought to identify the extent to which some staff’s views and opinions identified through early interviews, observations, and documentary analysis undertaken in the practice were shared by others. Participant

confidentiality was maintained with careful framing of questions such as: *“Some staff have told me in this study, not necessarily in this practice, that they think that practices don’t really need to formally collect feedback from patients as they will readily tell you what they think when they are here. To what extent do you think that’s the case in this practice?”*

### Shared Basic Assumptions - Observations and patient interviews

Shared assumptions of staff working in the practice staff were collected as I observed them work. This part of the study was focused on examining every day practice and seeking to understand why people thought or acted in particular ways.

Another source of data used to capture and examine shared basic assumptions held within the practice was interviews with patients who had recently used the practice. More detailed descriptions of the observations and patient interviews are now provided in turn.

Observations were commenced after staff became familiar with me in the practice. For the first 2- 3 weeks I spent time in staff areas but focused on examining documents. This allowed me to develop some familiarity with staff and clarify the study and the purpose of observations.

Practice staff and GPs were observed at the reception desk, administration staff work areas, during meetings and coffee/ lunch breaks. Observations were designed to be as least obtrusive as possible however when clarity was needed on why staff were undertaking tasks or acting or responding in particular ways this was sought as close to the event as possible. At all times I strove to ensure that such seeking of clarity did not adversely disrupt work flow or interactions with patient but at the same time allowed me to examine in detail the function of interactions between staff and between them and patients.

I observed interactions with patients at reception desks however I did not record anything stated by patients. This prevented the need to gain consent from every patient as they approached the reception desk and allowed me to observe practitioners engaging with patients in as close to the way as they

would do this normally. I did not observe clinical consultations as the focus of the study was on feedback that was given out with such consultations.

I took brief observation notes where appropriate to do so while in the practice. For example I did not take notes while I was in the staff coffee room or when staff engaged with me to share their opinions of patients or the practice. This was essential as it allowed me to become somewhat part of the “field” rather than as a distant data collector of technical data, which appeared to encourage staff to behave as they would normally and speak with ease to me and to their fellow colleagues. I made more detailed notes immediately after field work each day or at times when direct observation was not being undertaken. This enhanced accuracy of recall.

In addition to these notes I kept a reflective diary that guided further observations. I noted CMO configurations and lines of enquiry in this diary as I progressed in field work. For example *“the practice manager appears to think positive public reputation of the practice is important (O) but difficult to achieve amongst their local population (C) and this appears to have driven her to establish a Patient participation group (M) - I must ask staff what they think about this and look for evidence that either confirms or refutes that in observations, documents or interviews.”*

### Patient Interviews

Interviews with patients helped examine in a limited way, the extent to which practice staff perceptions of how they sought and responded to patient feedback (espoused values) were recognised, shared by and/or experienced by patients. Data from these interviews were also used to tentatively (but not conclusively) test some of the basic assumptions staff made about how patients view the service; know and understand the opportunities open to them to provide feedback; their preferences on how they their feedback should be sought and their likelihood to provide feedback.

Semi-structured interviews were conducted and were guided by a topic guide (appendix 11). The change in inclusion criteria necessary to secure recruitment of patients meant that questions about experiences of providing feedback to the practice could only be asked of those patients who chose to

disclose during interviews that they had provided feedback in the past. One practice had a patient participation group (PPG) therefore members of this group were asked some additional questions about their experience of being a PPG member and their perceptions of its purpose, its impact and how it could be improved in the future.

It is acknowledged that this source of data has some limitations. Firstly only a small number of patients were interviewed in each practice and due to resource limitations no attempts could be made to either reach saturation or to develop sample frames that could take account of practice population heterogeneity (142). It is also acknowledged that the patients who took part in the study were self-selecting and this along with the approaches used to recruit and to conduct the research could have unintentionally excluded some people from participating. Research into public participation in research studies highlights for example the under representation of marginalised groups e.g. those living in poverty, in minority ethnic groups, with learning difficulties, with a mental health condition, with a physical disability, who use illicit drugs and so on(143). Such marginalisation has more recently been highlighted to be as much of an issue within qualitative research as clinical research (144). Approaches to recruitment and data collection can be contradictory to beliefs, values and social norms of particular communities and therefore lead to a lack of participation or meaningful participation(145). It is acknowledged therefore that the use of practice staff to approach patients by phone, the lack of community supported recruitment of participants, the use of individual interviews to collect data and indeed my characteristics as an educated, middle aged and white woman recruiting patients and conducting interviews may have influenced who took part and how people engaged with the research interviews.

### *Data analysis*

The framework method (81) was used to analyse the data with the process continuing to be guided by Schein's organisational framework and the CMO. The framework method involves reading and re-reading of data sources, development of codes, labelling of data with codes and then the placing of data summaries into grids where data sources occupy rows and data codes columns. The grids allow

patterns and differences in the data to be identified and for further analysis across data sources such that further interpretation and explanations can be developed (81).

### Coding

All sources of data were transformed into written documents. Practice documents were summarised or copied, interviews were audio taped and transcribed verbatim and observation notes were made.

Interviews were transcribed by an independent company. All transcriptions were checked for accuracy against the audio file prior to coding.

Coding of all data was undertaken using Nvivo software using a coding structure partly informed by the programme theory and the findings of the review and partly by familiarisation with initial interviews, observations and documentation.

A number of iterations were made to the coding structure prior to it being applied to all data sources. In the early stages of coding there were 20 parent codes and 76 child codes. Initially this appeared to provide comprehensive coding of all sources of data. It was tested on one particular source of data – PPG minutes in one practice. This “test” demonstrated that multiple coding of text happened frequently as many codes had similar but not identical meanings. Coding to this micro level meant that:

- Some codes were not consistently coded to because it was impossible to remember all 76 child codes at one time.
- Coding became a long and complicated task that yielded diminishing returns as more codes were created.
- Multiple coding of text meant a high level of duplicated data when the whole data set was placed within a framework grid.
- Duplicated data within framework grids made analysis a very repetitive but no more of a detailed process than if a simpler coding structure had been used.

It was therefore judged that a more efficient and effective coding system was necessary. The coding framework was therefore revised and the 3 key assumptions and 3 research questions were used to

keep the analysis focused on the research questions and achievable within the time frame of the study.

The coding framework and how it relates to the research questions and the elements of the CMO configuration is detailed over leaf in Table 6.

**Table 6** High level coding structure and how it maps to 3 research questions:

Research Question	Codes
<b>Q1</b> How do practitioners working in General practice gain access to and use patients' experiences of healthcare? <ul style="list-style-type: none"> <li>How is such information obtained/presented to/shared amongst practitioners and managers within General practice?</li> </ul>	<ul style="list-style-type: none"> <li>Feedback mechanisms in use</li> <li>Content of patient feedback</li> </ul>
<b>Q1 continued</b> <ul style="list-style-type: none"> <li>How and why do practitioners and managers respond in particular ways to patients' experiences of healthcare?</li> <li>What strategies are individuals/teams consciously using to understand and improve patients' experiences of healthcare and why?</li> </ul>	<ul style="list-style-type: none"> <li>What's done with feedback?</li> <li>Mechanism 1 – deciding to make improvements</li> </ul>
<b>Q2</b> What factors appear to support/hinder the use of patients' experiences of healthcare to influence changes in GP services?  <b>and Q 1 continued</b> How do patients and practitioners think patients' healthcare experiences of services can be effectively used to improve services?	<ul style="list-style-type: none"> <li>Characteristics of practice</li> <li>Impact of feedback</li> <li>What influences what is done with feedback?</li> <li>Mechanisms 2 and 3 – using tight controls to implement non-complex changes and sustaining changes in practice</li> </ul>

## Analysis

Data analysis, like data collection was guided by Schein's framework and the principles of evaluation research.

### Data coding and analysis within cases – inter- case

Documents (artifacts(sic)) were coded and analysed using the framework method first and insights drawn from these were then compared with the insights drawn from the interviews (espoused values).

Findings from this were then compared with what was actually observed in practice (basic shared

assumptions). All data were constantly compared with the overarching programme theory and the CMO.

It was evident that in one practice there were a number of examples of improvements and therefore numerous CMOs could be developed to describe the factors affecting improvements. A restriction on words and time limited my ability to provide details of them all. Instead, consistent with that advocated by Pawson and Tilley (1997)(122), I chose four examples to best demonstrate the range of ways the practice responded.

### *Data coding and analysis across cases – intra-case*

Once each case had been analysed, analysis took place across cases using the CMO. The CMO was the guiding framework for this analysis and each assumptions about reasoning and actions was considered in light of the empirical findings. Each case was therefore compared to understand why some assumptions were upheld in some practices and not in others. This level of analysis supported the development of conclusions about how and why aspects of the proposed CMO did or did not reflect the everyday world of the three general practices studied.

### ***Rigour and credibility***

The aim in qualitative research is not to eliminate bias in study design and conduct but instead to recognise and acknowledge how ones viewpoints and previous experiences could be influencing the conduct of the research(142, 146).

### ***Being reflective during data collection and analysis***

Being reflective is recognised as an essential process by which qualitative researchers can become more aware of their viewpoints and how they might be influencing the research questions they ask, the focus they place on data collection and data analysis (147)(142). Bowling(146) highlights that most qualitative research methods texts recommend researchers to keep a reflective diary to record their feelings, reactions to data and their ongoing interpretations and impressions of data. I therefore kept a reflective diary during data collection and analysis and recorded my developing insights, thoughts and



impressions of the data and the particular assumptions and conclusions I was conscious of developing during data collection and analysis. While this was helpful and was repeatedly referred to, to guide observations and subsequent interviews or the next stages of data analysis some of the assumptions I made remained unconscious to me until I discussed my emergent impressions of the data with my supervisory team or participants in the research. The following details one example.

I was perplexed why one practice had been making efforts to improve patients' experiences of answering the phones prior to them receiving any formal feedback (complaints, survey results, suggestions or PPG comments) indicating that this was problematic for patients. Through discussion at supervision it became clear that I was assuming that improvement work related to patients' experiences could *only* be stimulated by formal patient feedback. Through recognising this I then sought to further investigate through my field work why this team had chosen this specific improvement, how did they know they had an issue? This data are referred to later in Chapter 5, Davidson example 2, page 129.

### *Use of CMOs*

As data collection and analysis progressed I also used the diary to record provisional CMOs that sought to explain how and why feedback was or was not being used within each case. This was used within the process of constant comparison where reflective questions posed throughout data collection and analysis were used during the development of data driven explanations of the contexts, mechanisms and outcomes associated with the use of patient feedback in general practice. As stated earlier in this chapter once intra-case analysis was complete, inter- case analysis was undertaken where particulars from each case were compared with each other, the CMO and programme theory. Intermittent return to raw data throughout the process of data analysis ensured that what was lost in summaries was not overlooked and continued to influence the emergent overall conclusions. This movement from raw to summarised data and from concentrating on the particulars of each case to comparisons across cases supported the development of more explanatory findings that supported a systematic review of the programme theory and proposed CMO.

Examples of questions posed within my reflective diary and used within the data analysis included:

- a) Is this (set of circumstance/ explanation) evident in all sources of evidence?
- b) To what extent is that (set of circumstance/ explanation) true in all circumstances; shared with all others in the practice; across the three practices, across all practitioners?
- c) Are there other explanations for this to be found in the data?
- d) Can I find data that challenges this current explanation and is there a particular reason evident as to why the current explanation does not stand up in that particular example?
- e) How does the explanation need to change in light of evidence that initially would seem to refute the initial explanations (moving from the specifics to the abstract explanations)

### *Acknowledging the potential impact of my presence*

In addition to being aware of how one's assumptions influence the research process it is also important to consider the impact of the researcher's presence. I was continually conscious of the impact my presence could have been having on the ways in which people behaved with each other and towards me. I therefore, in addition to the above, made conscious efforts to "blend in" to each team in each case in an effort to see the "reality" of their day-to-day work. The specific steps I took are detailed in the ethics section below as they were also central to ensuring good ethical standards throughout the research. It is acknowledged however that the presence of a researcher during ethnographic work has significant benefits in gaining detailed understandings of the social context in which people work and the patterns of discourse that take place(140). Such presence allowed me to explore staff's responses in real time to a wide variety of patient feedback that would not likely have been captured by purely speaking to staff in interviews. An example of this was the ability to watch and listen and engage with staff in Davidson practice after a patient had taken their perceived poor experience to the local press. Staff readily talked to each other about this and reflected with me on the views they had expressed in interviews about patients' expectations and ways of providing feedback, using this as an example to "justify" their perceptions about patients. Such encounters provided repeated opportunities to test out

emergent insights into the social discourse and attitudes that staff held and how these were formed and maintained.

### *Ethical Issues*

This qualitative study had a number of ethical considerations that required careful management. Data collection methods meant spending considerable amounts of time within the inside world of practices, observing teams and individuals while they worked, sometimes in places normally hidden from the general public.

This meant that I was privy to conversations about people's work and home lives, their frustrations about work which they might normally keep private from their managers and from those using the service.

Some were understandably curious and initially nervous of my presence in their practice and wanted to be reassured of the anonymity and confidentiality of anything I saw, heard or read. At the same time however many were interested and asked about other practices involved in the study and how they compared to those other practices.

Before starting case study work multiple site ethics approval was sought and awarded by the local medical ethics committee. Practices were asked to opt in to the study and were provided with comprehensive information about the purpose and nature of the study prior to agreeing to take part. In addition to providing written information I first met with each practice management team and then the administrative team to discuss the study and how it would be conducted.

The main ethical considerations were maintaining confidentiality of data collected within practices and maintaining staff and practice anonymity. As mentioned earlier in the chapter (pages 53 and 54) once assurance was given as to how data would be collected, stored and managed, informed consent forms from all members of the practice team was sought prior to case study work commencing. In addition, I sought verbal confirmation of each written informed consent with individuals prior to undertaking first observations of them or conducting interviews. This way I could be assured that they understood that

their participation remained entirely voluntary and that their data would be kept confidential and any subsequent reports would maintain their personal and practice's anonymity. All practices were also informed that pseudonyms would be used in all future references to their practice. The three pseudonyms used for practices were Davidson, Blair and Sutherland.

These guarantees of confidentiality and anonymity were designed to enhance recruitment (142, 148). Because many roles were covered by one person only, referral to specific roles in the findings would have contravened the guarantees for anonymity made at the outset of the study but such assurances contributed to an atmosphere of openness during observations and interviews. It did however mean that some findings from specific individuals have been reported as findings from "staff" where an individual would be uniquely identified. This limits the ability to discuss in detail any specific individual person or role contributions to the use of feedback.

In addition to gaining consent and using pseudonyms I consciously used a few strategies throughout data collection to build trust with staff. I spent 2-3 weeks in practices at the beginning of each case study getting to know staff, sharing tea and lunch breaks with them and generally trying to blend into their team. I for example in one practice joined their staff "weigh and save" club.

I always undertook documentary analysis first in each case prior to undertaking any interviews or observations. I used this time to become familiar with staff, the practice routines and to talk about the purpose of the research and the likely focus of observations. During that time I often had to reassure particularly, but not solely junior staff grades that I was not assessing their performance and was instead looking at how patient feedback flowed through the practice, what people thought about it and the challenges they faced everyday that may or may not influence how the practice deals with patient feedback. Once this was explained most staff appeared to be more comfortable around me and, over time they would share their personal reflections or frustrations they had had that day and talk openly to me or each other about issues happening with patients and/or other practice staff/GPs.

I also consciously tried to maintain a position where I was seen as neutral, not too close to staff, management or GPs. I for example made a point at keeping my time within each practice manager's

room to a minimum. I also never commented on any other group or member of staff but instead acted as more of a listening ear to those who chose to open up to me.

I also safeguarded confidentiality by never leaving data out in the practice for others to read. For example I was given access to folders of patients' complaints in two practices. I never left the folder out while on breaks and ensured it was returned to the practice manager's room while I was not using it. I also kept a notebook for data collection and always kept this on my person. Another example of this was my responses when staff asked questions about other practices. I gently reminded them that it would be wrong for me to disclose who else was taking part as I had provided these other practices with the same assurances as I had provided this practice.

All of these behaviours provided concrete examples to practice staff of how careful I was being with their comments, views and work activity and demonstrated that I took the responsibility of having knowledge of their practice seriously.

In all three cases I found staff became increasingly friendly towards me and more relaxed while I was around. GPs and practice managers gave me access to electronic files on their shared drives and permitted me to copy such documents onto my lap top. Staff often disclosed their frustrations of their job in more general terms. Practice managers and GPs shared their plans for the practice with me and shared their frustrations and pleasures of their roles. Some staff even talked to me about their personal lives. Only in one practice did one member of staff withdraw from the study. However after this happened many staff came and told me personally that they did not agree with her beliefs about the study and they had no issue with me being in the practice and were enjoying taking part.

This along with the frank conversations I heard in practice and the varied views of patient feedback and its use provided within interviews gave me some assurance that staff felt reassured that the study was being conducted ethically and as a result functioned in their roles as close to how they would normally, in the absence of an outsider observing their practice.

## Summary

This chapter has provided an overview and rationale for the use of realistic evaluation methodology within this study. It has described the 2 key methods, realist review and comparative case studies utilised and how they were applied to the investigation into how patient feedback is used within general practice. The following chapters 3-6 now detail the findings from the study.



## Chapter 3 Stage 1: Realist Review Findings

### Introduction

This chapter describes the findings of the realist review conducted to analyse the policy informed programme theory of how patient feedback is thought to operate in primary care teams in light of the empirical evidence. The chapter concludes with a revised programme theory whose integrity was further tested in stage 2 (the realist evaluation) of the study.

### *Review findings*

The electronic search identified 6867 (not de-duplicated) publications. Nineteen full text articles were independently assessed by DB, VE and BG and 9 met the inclusion criteria (table 4). Three further papers were found after reviewing the reference lists of these 9 papers. No further studies were identified through hand searching of 2 key journals.

The 12 papers found reported data from 10 studies, and for clarity findings subsequently referred to as findings from 10 studies rather than the 12 papers. The 10 studies are summarised in Appendix 3.

### *Summary of study designs*

Nine studies prospectively examined whether the use of patient feedback was associated with improvements in future patient experience. These are referred to as the intervention studies. One (149), surveyed practices to identify which surveys they had previously used to gather patients' experiences and how they had used results to improve their service. Most (5/9) of the intervention studies used instruments that elicited patient assessments of both physician and practice performance. These included the Improving Practice Questionnaire (IPQ)(133, 150), the General Practice Assessment Questionnaire (GPAQ)(151); Patient Assessment of Health Care Plans - Consumer Assessments of Healthcare Providers and Systems (CAHPS) (108, 152) , the Chronically Ill Patients Evaluate General practice(CEP) (153, 154). The other four intervention studies used patient satisfaction surveys (155-158).



The ways in which survey data was analysed and fed back varied considerably. Most (6/9) interventions consisted of provision of written feedback at the practice (i.e. organisation) level in a comparative (n=3) (150, 151, 156) or non-comparative format (n=3) (152, 155, 157). Two interventions included the provision of comparative feedback at the individual practitioner level (133, 153, 154). One provided aggregated practice level data to practice managers in addition to confidential practitioner level data to each practitioner(133). The ways in which practitioners received feedback was not reported in the remaining study(149).

The majority (7/9) of intervention studies combined feedback with other interventions including: participation in a quality improvement collaborative (108, 152); physician reimbursement (156);provision of a report detailing the determinants of patient satisfaction and an improvement guide (153, 154) and quality improvement activities/meetings (150, 155, 157). The two remaining studies used feedback alone (133, 151).

Primary outcomes fell into 2 main categories – 1) patient experience and 2) staff reports of experience of receiving or using feedback. One study also analysed video footage of consultations to assess the changes in communication after the provision of feedback(154).

***Q1 Is the use of formal patient feedback associated with changes in future patients' experiences in primary health care settings?***

Patient experience scores were used as primary outcome measures in 6 studies (150, 152, 153, 155, 156, 158). Regardless of instruments used, methods of feedback to practitioners or the context, there is little or no evidence from published studies that the use of formal patient feedback at practice or practitioner level within primary care settings leads to improvements in future patients' experiences. At its most basic, written feedback combined with a practice meeting focused on understanding survey results, resulted in no statistically significant improvements in overall Improving Practice Questionnaire (IPQ) scores after 6 months(150). At the more complex end of the spectrum a study that included monthly feedback and intense facilitation and support, over a longer

time period (18 months), both positive and negative changes in patient experience scores were seen, however very few were statistically significant or linked to the initial improvement goals that teams set (152).

There was a similar lack of evidence of effectiveness in the two quality improvement reports. Teams were noted to have had variable levels of success in improving patient experience scores in one report (18) and statistically significant improvements in patients' scores were seen in just under half of the patient experience survey item scores in the other (155)

***Q2What appears to influence the use of formal patient feedback in primary health care teams and is validity important?***

Understanding what influences improvement activity, stimulated by patient feedback is limited by the few studies that have examined this in primary health care settings. This review did identify however a number of contingent circumstances and characteristics of interventions and target groups that appear to influence whether or how formal patient feedback will be listened to and acted upon by practitioners and ultimately that improvement efforts will impact on future patients' experience reports. These include: the perceived purpose of patient feedback; type of data that are collected and their presentation; perceived validity of data; timeliness of feedback to practitioners/teams data and the context it is presented to primary health care teams or practitioners.

***Purpose***

Practitioners' perceptions of the purpose of gathering and considering patient feedback appear to influence their responses to it. In studies where teams had sought patients' views themselves and used them to inform quality improvement activity, perceived benefits were consistently reported by staff (149, 155, 157). In contrast, one qualitative evaluation of 42 primary health care teams' experiences of receiving patient feedback from a research team found staff responses to patient survey results to be mixed. Researchers in this latter study attributed variance in staff responses to

the differences in how patient feedback had been promoted at practice and Primary Care Trust level. In particular, GPs were found to be anxious that such data might be used to judge their personal performance rather than be used for educational and developmental purposes (133).

### *Type of data and their presentation*

Careful attention to the survey design, data analysis and presentation appears to be critical to fostering motivation to change. GPs were not reported as challenging data validity or attributing variation to specific socio-demographic characteristics where robust analysis of data took account of such confounding variables (152, 153).

The format in which patient feedback is presented and fed back to health care staff may significantly affect its potential to stimulate improvement efforts. Intervention study findings indicated that staff were more likely to attempt to change practice when survey data a) were presented in accessible formats(152), b) had appropriate reference points e.g. comparisons with similar health care providers/practitioners(133), c) had experience scores reported alongside importance ratings(108, 152), d) was care process and practitioner specific, sufficient enough to support easy identification of areas for improvement (108, 152, 154, 156, 157), and shared in ways that were acceptable to the individual GP (anonymity/confidentiality if preferred)(152, 153).

Provision of data that were care process and practitioner specific did not consistently act as a precursor to an intention to act however. One study found for example that GPs exposed to individualised feedback of that nature (i.e. they knew which aspects of care needed improvement) saw significantly less need to change their own practice after receipt of feedback when compared with those who did not receive any feedback (153).

One method, which fed back data in “focus charts” that plotted patient experience domain average scores against the degree to which each experience domain statistically contributed to overall satisfaction ratings appeared to not only alleviate criticism of data, but be viewed by practitioners

and improvement leaders as having supported teams to readily identify priorities for change(108, 152).

### *Validity of patient feedback*

Some clinicians have expressed concern about the reliability and validity of some measures of patients' experiences (152). The focus of questions within patient surveys appears to influence clinicians' likelihood of acting on feedback. Questions perceived as important amongst general practitioners for example have been found to enhance the attention they pay to survey results (152). There is also some evidence to indicate that surveys which are sufficiently flexible to highlight areas of concern and allow service providers to "dig deeper" into poorer ratings have been more widely viewed as useful by service providers (108, 152, 156, 157).

### *Timeliness*

Data that were gathered, analysed and presented in resource efficient and unobtrusive ways have been perceived as helpful by GPs (151) and supportive of effective decision making in teams (152). The importance of the duration of time between patient feedback being sought and shared with practitioners is unclear. In one study improvement leaders reported that practitioners developed apathy when they experienced delays with feedback of patient experience data(152). Evidence from the same study however indicated that groups who made the most improvements in patients' experience scores(albeit not statistically significant) were those who, contrary to what was expected, never referred to their monthly online data but instead; looked at their data once, or at most, quarterly, then designed and implemented changes and considered their impact towards the end of the study.

### *Context*

A lack of leadership committed to quality improvement has been cited by health care staff as a key barrier to making improvements in practice in response to patient feedback (152). An inability to include patient feedback results within "full agendas" of strategic meetings was provided as a reason

for non participation of 2/4 Primary Care Team Boards in a study designed to identify the impact of patient feedback(133). A requirement for commitment to all aspects of quality has been reported as critical to achieving improvements in patient satisfaction/experience scores (108, 150, 155) or in medical care continuity(157). Another study however, highlighted that despite strong commitment to learn and change practice in response to patient feedback, GPs found it difficult to change their practice and their patient experience scores (153) and became sceptical of its value once exposed to survey results.

The extent to which patient feedback matches medical staff's opinions of their own or their practice' service also appears to influence attitudes towards formal patient feedback. Feedback that was positive and reflected practitioners' assessment of the service was viewed as motivating (133, 155, 157) by GPs. Similarly feedback that was critical but matched the team's own view of the limitations of the service appeared to galvanise efforts to change (133, 155, 157). In contrast, where patients' feedback has been critical of services and this did not match practitioners' views, medical staff tended to be sceptical of the data or methodology or requested larger sample sizes (108, 133, 150).

The research reported to date suggests staff's attitudes and likelihood to change in response to patient feedback are not predictable or static. Scepticism over the quality of patient feedback data was reported in two studies (133, 153)but not reported in others. While this may be an artefact of inconsistent reporting there does appear to be a pattern to the difference in staff attitudes across studies. Scepticism over the validity or relevance of patient feedback data was only reported in studies where practitioners were provided with data gathered by others and not when the primary care team decided to collect and consider their own patient feedback.

As well as difference in attitudes of staff across studies, one study(153, 154) demonstrated that attitudes to patient feedback can change over time within a study population. Doctors in the intervention and control groups in this study had comparable levels of motivation to learn from patients at the outset. Fewer of the intervention group, who received patient feedbackabout their

personal performance considered it to be practically relevant after they had received it and a greater proportion considered it to be time and energy consuming and saw little reason to change their practice (153, 154).

***Q3 What appears to influence the effectiveness of efforts (stimulated by patient feedback) aimed at improving future patients' experiences in primary health care?***

Many studies indicated that staff had reported making attempts to improve (133, 149, 151, 152, 154-156, 158) but had experienced key barriers to implementing or sustaining such changes. In a study of US medical groups where such barriers were reported some medical groups appeared to be more successful than others (15). Teams who used available external facilitation support or had implemented modest, non-complex changes using tight management controls were the most likely to successfully implement change (108, 133, 152). Findings from a large study of GPs in the UK and two quality improvement reports from a university health centre in Hong Kong and a USA family practice centre indicate that successful implementation of change in response to patient feedback appears to have been significantly influenced by the fit between the improvements and the strategic priorities of the department or organisation (133, 155, 157).

Key barriers cited by research participants included competing organisational priorities and lack of improvement staff to facilitate change (108), budgetary restrictions, lack of time and high workload requirements (133, 151, 152). One study examined the effects of financial incentives although the effect of this remains unclear as findings from this study were equivocal (156).

Medical communication training was an intervention implemented in response to patient feedback by some of the teams in the Davies and Cleary (2008) study (152) and like financial incentives, its impact remains unclear. One team who chose to implement medical staff communication skills training in response to their patient feedback found a slight improvement in patients' reports of medical staff explaining things in a way that was easy to understand but a decline in patients' reports of the time doctors spent with them. Another group found that medical staff communication

training led to unintended consequences amongst medical staff, who perceived elements of the study package to conflict with their views about their own personal performance (152).

## Discussion

This realist review aimed to consider how the use and influence of formal patient feedback in general practice compares with the “official expectations” implicit within UK health care policy (Figure 3, page 35). The transformative capacity of patient feedback assumed in much health care policy was not demonstrated in published research studies in primary healthcare to date. Few studies (n= 10) explored the use of patient feedback within the primary health care setting and fewer still (n=6) examined its impact on future patients’ experiences. Contrary to programme theory assumption 1 - *there are valid and reliable ways of measuring the patient’s health care experiences for use in feedback*, studies highlighted that primary care staff, particularly GPs, frequently express concerns about the validity of patient experience surveys and such concerns potentially limit the likelihood that programme theory assumption 2 will be upheld. That is, practices are probably less likely to see the need to or make changes in response to feedback if they are skeptical of the validity of that patient feedback.

Furthermore the review highlights that even when improvement efforts are stimulated, there are a number of issues that affect the likelihood that *improvement efforts initiated by organisations, teams or individuals lead to improvements in future patients’ experience of health care* (Programme theory assumption 3).

Comparison of the findings from this realist review with a recent Cochrane review indicates that the provision of patient feedback data to clinicians appears to differ in important and significant ways from the provision of feedback data about other aspects of clinical practice. Patient feedback appears to be, overall, less effective in stimulating changes in practice than audit and feedback about other aspects of clinical performance although the latter is also variable in its impact on

clinical performance and patient outcomes, ranging from little or no effect to a substantial effect(63). Furthermore, while initial poor performance was found to be an important predictor of subsequent change in clinical performance and a positive relationship was found between the number of times clinical staff received feedback and positive changes in clinicians' behaviour (63) this realist review of patient feedback indicates that poor performance is rarely detected with current approaches to measurement and the intensity of patient feedback is rarely stated.

This [realist] review of patient feedback also found that other factors found in the Cochrane review (63)to enhance the impact of audit and feedback of clinical data such as the provision of feedback by a supervisor/colleague; feedback provided verbally and in writing and presence of clear targets and action plans were not highlighted by researchers or research participants as key influencing factors in patient feedback studies. Instead, other issues such as the purpose and validity of data, data presentation (types of charts, use or normative comparisons, confidentiality etc), resources and the prevailing cultures of teams receiving such feedback were cited as being more influential in mediating how feedback was acted on.

Findings from this realist review has demonstrated that the process of changing practice in response to formal patient feedback is more complex than that depicted in current health policy. External facilitation does appear to show some promise in supporting teams to at least initiate improvement efforts but even when teams report engaging in improvement activity, changes in patients' experiences are not consistently found.

Hospital-based studies have reached similar conclusions to those made in this review, indicating that significant attention needs to be paid to the quality and type of data if staff resistance is to be avoided(31, 64, 159, 160). More specifically, it has been suggested that the scientific basis of instruments, (particularly construct validity concerns such as combining items that focus on evaluations of the organisation/context of care with the performance of individuals) need to be overcome if scepticism of patient feedback surveys is to be minimised (59).Studies of hospital use of



patient feedback also highlight that there is no “best way” to share patient feedback with health care staff. Instead, agreements between regulators/survey providers and health care staff as to how data are to be shared appears to be key in helping mitigate clinicians’ anxiety and thus resistance to patient feedback programmes (161).

## Conclusions

A range of conclusions can be drawn from this review. Most simply, patient feedback could be viewed as ineffective or at least unproven in improving patients’ reports of their experiences. Alternatively it is possible that demonstrating evidence of empirical links between formal patient experience feedback and improvements in future patients’ experiences has been hampered by a lack of research. Specifically, limitations of current patient experience measures, complexities in measuring patient experience, the predominant use of qualitative or uncontrolled longitudinal study designs and the complexity inherent in designing and controlling the complex interventions aimed at influencing patient experience have all contributed to the current lack of evidence of effectiveness and explicit explanatory theories.

This review does make clear however that the evidence to date does not strongly support the prevailing policy assumption of the transformative capacity of formal patient feedback. Work is still ongoing to find ways of collecting patients’ feedback in valid and reliable ways (programme theory assumption 1). Critically, for patient feedback to be effective, the recipients of feedback have to be *persuaded* that it is valid and reliable and the evidence indicates this is often not the case irrespective of the actual technical properties of the instruments used. Formal patient feedback does not always stimulate teams or individuals to make changes in practice (programme theory assumption 2). Instead, changes in practice can be influenced by the intervention; the responses practitioners have to the intervention and the context in which the intervention is placed not all of which are well understood. Finally, even when teams engage in improvement efforts (programme theory assumption 3) evidence of their effectiveness is varied and influenced both by the ability of

the outcome measures used to reliably capture change and the variance in teams' / individuals' capacities to implement and sustain such changes in practice.

Overall, it remains relatively unclear as to how to best achieve improvements in patients' experiences of care in primary health care at practice or practitioner level even when patients' feedback identifies aspects of care that could be better. It is recognised as naïve to expect that measurement and feedback of results to teams alone will lead to sustainable change (117) and this review has confirmed that even when formal patient feedback is combined with intense and focused improvement efforts, statistical improvements in future patients' experiences is rare. The literature however available is scant, and caution should be noted as absence of evidence of effectiveness is not the same as evidence of ineffectiveness.

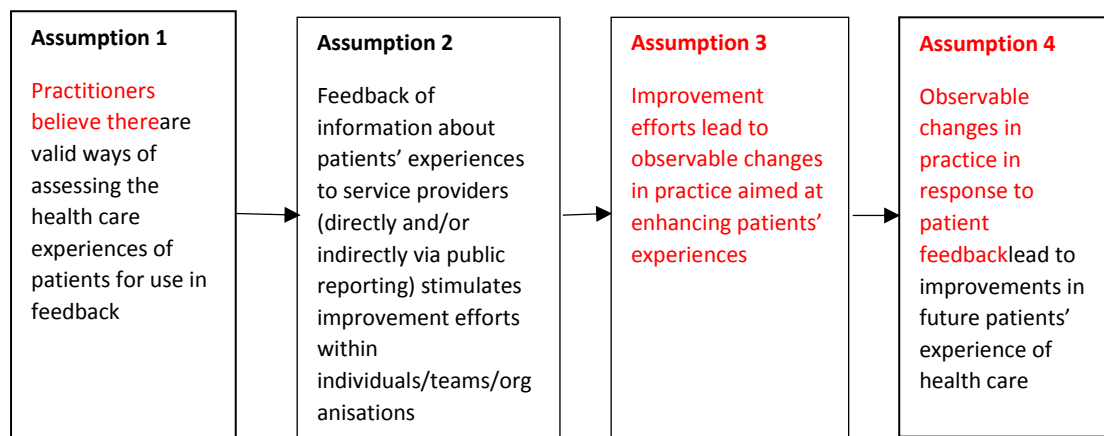
There is some observational evidence that improvement efforts are more likely to have some success when aligned with organisational strategic priorities. There is also some evidence to suggest that medical staff' criticism of and resistance to patient feedback can be somewhat ameliorated by attention to the measurement tools and approaches to data collection, analysis and presentation and agreements between regulators and GPs on how data are to be used.

Studies into the use of formal patient feedback within primary medical settings have to date focused on the impact and/or use of patient survey data. With the exception of one study (153, 154), none controlled for other recognised variables known to contribute to variation in patient experience scores such as patient age, education or self-reported health status (162). Many studies relied on staff reports of the impact patient feedback had on practice and as a consequence had a high potential for a) socially desirable responses and b) under/over reporting of improvement activity/impact. Despite this there was little evidence of an association between patient survey feedback and future patient experiences.

As indicated above, because research into the use of feedback in primary care is limited it would be inappropriate to make significant changes to the initial programme theory at this point of the study.

One consistent finding however is that when patient feedback is reported to lead to decisions to make improvements, changes in practice are reported by staff. This is proposed therefore as an important interim step between assumptions 2 and 3 in the initial programme theory (Figure 3, page 35). The refined programme theory below (Figure 7) has been slightly updated to show the importance of practitioners' beliefs and to introduce a new assumption that demonstrates that although changes may be observed in practice following a decision to change, these may or may not lead to the identification of discernible changes in future patients' feedback.

**Figure 7 Refined programme theory**



This refined programme theory is also now described in CMO terms using the findings from the realist synthesis. It has three key mechanisms that explain the generative process that is believed to lead to the outcome of improvement in future patients' experiences of care. These mechanisms are not necessarily new but they have, until now, been largely implicit and untested.

The lack of attention paid to generative causation in previous studies has meant that explanations of the sequence of mechanisms (reasoning and actions) required to achieve observable improvements in patient experiences and how this process is influenced by context have gone largely unexplored. These mechanisms such as deciding to make changes, attempting to make changes and successfully implementing them in practice act like stepping stones that lead to the end outcome (changes in patients' experience). They do not happen in isolation however. Rather they occur in a stratified

social reality (context) that influences how practices engage in reasoning and weave this with their human and other resources. The CMO that is used to guide Stage 2 of this study is now explained in more detail.

## **Proposed CMO**

Rather than it being assumed that there are valid ways of assessing patients' feedback, the review has indicated that practitioners need to believe that the ways in which feedback is gathered from their patient population is valid before they are likely to consider the need for improvement and take action to try and improve patients' experiences. GPs' opinions of the tools used, how they are applied in practice and how the data are analysed and presented appear to influence their perceptions of data validity. Their opinions have also been found to be more positive to data when they have agreements with regulators over how the data are to be used. Efforts aimed at enhancing patients' experiences is more likely to happen if these validity issues are addressed, practitioners perceive improvements are needed and the practice leadership has a focus on continually enhancing patients' experiences.




Another implicit assumption within the programme theory is that improvement efforts directly and consistently lead to changes in patient experiences. Evidence from the review indicates that although changes in patients' experiences may not be discernible teams may have initiated improvements. The likelihood that improvements will be initiated and indeed sustained also appear to be influenced by other factors. First of all, teams' perceptions of practice experiences need to firstly match their own if they are to be motivated to change. They appear more likely to successfully implement changes when they find a strategic fit between changes needed and organisational priorities; implement relatively simple changes with tight management controls and access external facilitation to support their changes. Such improvement efforts (M) may then lead to observable change(s) in practice. Observable change(s) (M) in practice are now within this CMO seen as a

critically important mechanism (a step), likely to be an essential precursor to improving patient experiences:

Lastly, the review indicated that thus far the lack of evidence of discernible improvements in patients' experiences may be as a result of methodological limitations associated with the use of patient surveys with ceiling effects and/or contextual factors limiting teams' abilities to make and sustain changes in practice.

The process therefore from feedback being provided through to improvements in future patients experiences is not straight forward. The sets of reasoning and related actions that take place along the way are represented in the CMO in Figure 8 overleaf.

**Figure 8 proposed CMO - how patient feedback leads to improvements in future patients' experiences of care**

Context +	Mechanism(s) =	Outcome
<b>Practices:</b> <ul style="list-style-type: none"> <li>are resourced to provide good patient experiences</li> <li>view patient experiences as a key quality outcome and</li> <li>have access to timely patient feedback data</li> <li>are structured in ways that supports improvements to be readily implemented</li> <li>have access to data that are capable of detecting small changes in patient experience</li> </ul>	<b>Stage 1 Reasoning :</b>  When faced with patient feedback, teams collectively believe: <ul style="list-style-type: none"> <li>that feedback is for improvement and not external judgement</li> <li>data are presented in easily understood ways that meet GP preferences</li> <li>patient feedback is valid</li> <li>that experiences need to be improved</li> </ul>	Changes in practice are detected in future patient feedback scores
	<b>Action 1: Team decide to try and make improvements</b>	
	<b>Stage 2 Reasoning</b>   Teams: <ul style="list-style-type: none"> <li>acknowledge that patient feedback is consistent with what staff already see as improvement priorities</li> <li>find a strategic fit between organisational priorities and patient feedback informed improvement priorities</li> <li>perceive the changes to be relatively non- complex</li> </ul>	
	 <b>Action 2: Team use tight management controls to make non-complex changes and access external facilitation</b>	
	 <b>Action 3: Team find ways to sustain changes in practice</b>	

Although this CMO has been informed by the empirical findings from the realist synthesis it remains a set of proposed explanations *or assumptions* about how feedback is thought to lead to improvements in future patients' experiences. It therefore provides a framework that can be

compared with the reality of what happens in practice and was used to guide the case study element of this study.

## **Chapter 4 Summary of case study data collected and case characteristics**

### **Introduction**

The case study method is used in this realistic enquiry to explore how the features of each case appear to influence how practices seek and make use of patient feedback. This chapter details the types and volume of data collected during fieldwork in each case before it describes the key contextual features of each practice. The ways in which particular features of each practice relate to the gathering, use and impact of patient feedback are detailed in future chapters.

Three key features of each practice's context are described. These include practice size and some characteristics of each practice population; physical environment of each Practice and a description of how they each conduct business.

Each Practice and the population it serves is first described using data collected from national statistics. Descriptions of the physical appearance of each practice are drawn from observations in the initial 2-3 weeks in each practice. Descriptions of how the practice conducts business include details of how each practice is led and managed and how it makes decisions and so forth. These descriptions are drawn from my analysis of documents produced in the 2 years prior to, and during, fieldwork; informal discussions with staff, predominantly the practice managers; and detailed observations of staff throughout the data collection period.

### **Data Collected**

Three practices were recruited to the study in accordance with the sampling strategy.

Practices were given pseudonyms to protect their anonymity – Davidson Practice (D), Blair Practice (B) and Sutherland Practice (S). All data that uniquely identifies practices has also



been approximated to assure them anonymity. Each case includes the practice, participating patients and any NHS staff who provide clinics for general medical services (GMS) care within the practice. Originally it was thought that the CHP within which the practices sat may be important. As each case study investigation progressed however, it became clear that the activity relating to patients' experiences of the practice was almost entirely determined within the practice, rather than by any structures or processes outside of the practice. For example, I never saw or heard any references made by participants to the CHP and its influence on what the practice would/ should do in relation to enhancing patients' experiences in interviews, observations or practice documents.

### ***Routine data***

All demographic data relating to the practices was obtained from publicly available data held by NHS National Services Scotland Information Services Division (163). Deprivation scores and other neighbourhood statistics are taken from the Scottish Neighbourhood Statistics website [www.sns.gov.uk](http://www.sns.gov.uk) (164). Deprivation is described using the Scottish Multiple Index of Deprivation (SIMD). SIMD ranks postcodes quintiles. "Quintile numbering should be interpreted on a scale where value 1 = most deprived and value 5 = least deprived." (165)

### ***Documents***

All Practices gave me full access to all the relevant documents I requested. Both of the smaller practices had significantly less documentation to review than the larger practice. Where available, I examined relevant documents for up to 2 years prior to fieldwork in each practice. In some cases there was only data available from 2011 onwards, the remainder having been archived. There are significantly more documents than this in each practice that relate to how to clinically manage patients with certain conditions and symptoms - protocols, pathways of care and so forth. These were not reviewed as governance of clinical care was not the focus of this study.

**Table7- Documents reviewed**

<b>Document type</b>	<b>Davidson Practice</b>	<b>Blair Practice</b>	<b>Sutherland Practice</b>
Complaints and responses	28	None	4
Significant event analysis	10	None	8
Patient participation group meeting documents (agenda, minutes, terms of reference)	11 minutes Patient comments poster	0	1 planning document
New patient booklet	Yes	Yes	Yes
Practice website	Yes	No	No
Staff induction materials	Yes	No	No
Patient feedback in the press	1 negative patient experience in local press	No	No
Patient suggestions	Yes Comments from waiting room feedback campaign	No	No
Patient survey results 2009/10 & 2011/12	Yes	Yes	Yes
Practice staff meetings agendas and minutes	Practice nurse meetings – 4 Reception staff meetings – 3	Practice meeting – 30 Reception staff meeting- 5	Reception staff meetings – 55
Partners' meetings agenda and minutes	18	N/A	N/A
Protocols for reception staff on how to communicate with patients	2	1	0

Notices suggesting patient feedback was welcome	3	0	1 - restricted to how to complain /raise concern
Patient notice boards	2	5	3

Prior to presenting the findings from all of this data in the subsequent two chapters the following section provides rich descriptions of each case.

### ***Staff interviews and observations – recruitment details***

Staff and GPs were either approached individually or provided with information sheets and consent forms at meetings arranged to discuss the project during the recruitment period. Consent forms were completed by those who wished to take part in the study. Details of staff recruited within each case are provided over leaf:

**Table 8 Staff recruitment figures**

Practice Role	Number approached			Number consented to observation			Number interviewed			Total Interviewed
	D	B	S	D	B	S	D	B	S	
GP	8	3	2	8	3	2	8	3	2	<b>13</b>
GP trainee	1	1	1	1	1	1	1	1	1	<b>3</b>
GP locum	0	2	0	0	2	0	0	2	0	<b>2</b>
Pharmacist	1	1	0	1	1	0	1	1	0	<b>2</b>
Practice manager	1	1	0	1	1	0	1	1	0	<b>2</b>
Practice nurse	4	4	1	4	4	1	4	4	1	<b>9</b>
Health visitor	1	1	1	1	1	0	1	1	0	<b>2</b>
Health care assistant	3	0	1	3	0	1	1	0	1	<b>2</b>
Receptionist	4	7	3	6	6	3	2	6	3	<b>11</b>
Administrator	7	1	0	8	1	0	5	1	0	<b>6</b>
<b>Total</b>	<b>30</b>	<b>21</b>	<b>9</b>	<b>33</b>	<b>20</b>	<b>9</b>	<b>24</b>	<b>20</b>	<b>8</b>	<b>52</b>

D = Davidson    B = Blair    S = Sutherland

All but one of the staff in the 3 practices (59/60) agreed to be observed. One receptionist in Blair Practice noted to me after the first 2 weeks of observations, that she was unhappy being observed and perceived observations as intrusive. They also noted their strong belief that through observations I was appraising their personal performance and results would be shared with the management, who, they stated, they did not trust. Despite further clarification about the purpose of observations and reassurance of the governance around data being confidential and anonymous this person withdrew their consent to be observed and interviewed. As this receptionist was a part- time worker subsequent observations were undertaken on days they were off duty and documentary analysis was undertaken in a separate work area on days where field work coincided with the person's work days.

52 of the 59 staff who consented to be observed as part of the study also agreed and took part in interviews. Reasons for not participating in interviews were mixed. One Health Visitor in Sutherland Practice failed to respond to any invites to an interview and also was never seen in the practice during any of the field work. To HCAs, two administrators and two receptionists in Davidson Practice refused to take part stating they were uncomfortable being interviewed but happy to be observed and to have informal chats about their work while being observed.

### ***Number of observations***

Observations of staff working were undertaken after 2-3 weeks in each practice following informed consent of all staff. Table 8 details the number of hours of observations undertaken in each practice:

**Table 9 Observation hours**

<b>Practice</b>	<b>Observation Hours</b>
Davidson	82
Blair	56
Sutherland	61
<b>Total</b>	<b>199</b>

### ***Patient interviews - recruitment details***

The numbers of patients approached and the number consequently interviewed are detailed in Table 9 overleaf.

**Table 10 Number of patient interviews**

Number of patients approached/noted interest			Number of patients interviewed			Total interviewed
D	B	S	D	B	S	
17	12	5	11	4	4	19
			<b>Patients</b>			
			4 women	1 woman	2 women	9 women
			1 men	3 men	2 men	10 men
			<b>PPG</b>			
			2 women			
			4 men			

D = Davidson    B = Blair    S = Sutherland

In Davidson Practice, of the first 10 patients identified, four were interviewed. Seven agreed to be interviewed however three cancelled on the day of the interview. Two patients could not be contacted and one declined to take part stating they had only recently joined the practice and felt they had no opinions to share. In addition to those 10 patients approached by staff, one patient made contact by email after seeing the waiting room recruitment poster and was subsequently interviewed. Six interviews with PPG patient members were also undertaken in this practice. A total of 11 patients therefore took part. Nine were conducted in the practice and two were conducted in patients' homes.

Ten patients in Blair Practice were identified by staff. One patient I approached declined to take part and one was not contactable. Of the eight who agreed and arranged an interview time, six did not attend their interview appointment. With only two patients having taken part, a further two patients were identified by staff and both subsequently took part in interviews. All four interviews took place in the practice.

In Sutherland Practice, only five patients were identified to begin with as the Practice thought that few patients would be likely to decline to take part or not turn up for an arranged interview. One patient could not be contacted. Consistent with staff's predictions, four agreed and subsequently took part in an interview. Three interviews were conducted in the Practice and 1 was conducted in a patient's home.

## **Practice characteristics**

### ***How each practice team described themselves during recruitment***

During the recruitment process the Practice manager of Davidson Practice in Community Health Partnership 1 (CHP1) told me that they make concerted efforts to engage with patients using a range of approaches including having a patient participation group (PPG). They also indicated that they used patients' feedback to inform service delivery and improvements but are bemused and at times upset that they continue to receive a significant number of complaints from patients. This Practice therefore met the first criteria - a case that appears to readily make use of patient experience feedback.

The practice manager of Blair Practice in CHP2 when discussing participation in the study indicated that they did not make any specific efforts to seek feedback from patients and had received no complaints in the previous two years. Although like all Scottish Practices their patients had taken part in the national patient experience survey she noted that the Practice had received no report this year (2011). They therefore met the second criteria - a case that appears to make little use of patient experience feedback. The practice manager also noted that the practice was not particularly dynamic and tended to "stick with tradition" in terms of how it delivered services.

The third criteria was - a case that is similar (in terms of patient experience feedback use) to one of the two identified above but is based in a different CHP. Sutherland Practice was

similar to Blair Practice in that they indicated that they too had made no specific efforts to seek feedback from patients but was located in a different CHP – CHP1. The primary care manager indicated however that although this Practice did not do any specific work in regards to seeking or acting on patient’s feedback they tended to be a “dynamic” practice who often piloted new ways of providing services for the CHP and often supported research.

### ***Location, size and demographics of each practice***

The practices differed in size, patient populations and communities they served. Table 11 overleaf summarises some key characteristics of each practice.

Blair Practice serves a far more socioeconomically deprived population than the other two, and has a significant number of drug users registered. Most up to date SNS data indicates that ~ 30 per 100000 population of people living in the neighbourhood of the Blair Practice were admitted to hospital for drug misuse between 2001 and 2004 (SNS data, accessed 01/05/2013). A report produced by one of the GPs on the profile of people registering within the Practice over between May 2008 and May 2009 indicated that 17. 8% of new patients registering were drug users. The report author informed me that although they did have a high proportion of drug users registered they were provided with their addiction support medication direct from drug services and the Practice only prescribed their non--opiate drugs. Admissions to hospital because of drug misuse during the same period (2001-2004) were significantly lower in Davidson Practice neighbourhood Practice at ~7 per 100000 population ([www.sns.gov.uk](http://www.sns.gov.uk) accessed 01/05/2013). No data is available for the neighbourhood in which Sutherland Practice is located ([www.sns.gov.uk](http://www.sns.gov.uk) accessed 01/05/2013) however this Practice indicated that they have no drug users registered.

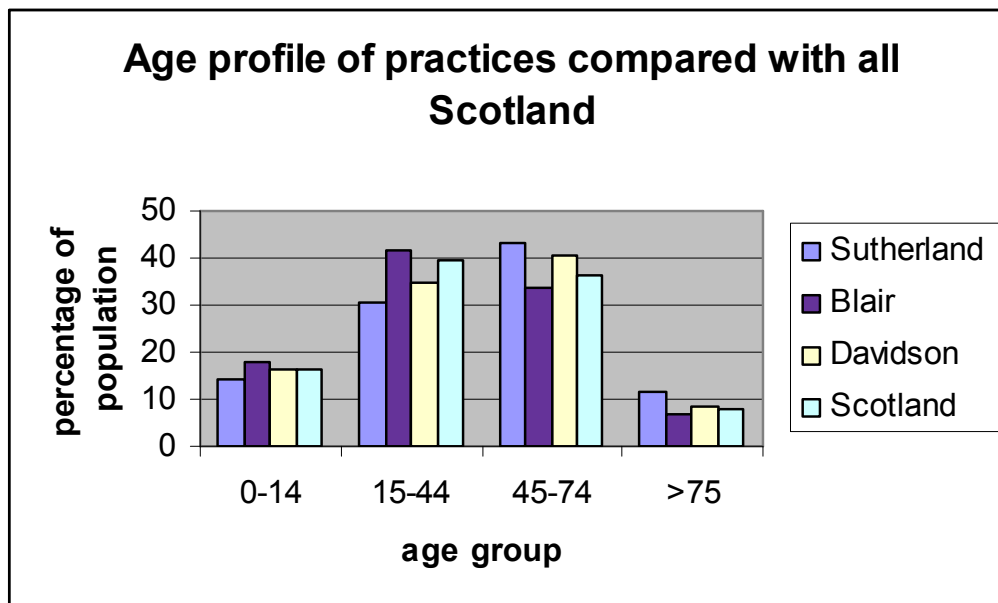


**Table11 Practice characteristics**

Practice	Location	CHP	Patient population size	SIMD scores:	Number and status of GPs	Training practice?	Practice management
Davidson Practice	Suburban market town, with a significant commuter population.	1	>8,000	Majority patients in 4 <sup>th</sup> and 5 <sup>th</sup> (least deprived) quintiles.  No patients are living in areas defined as the 15% most deprived.	>6 mostly working part time with other commitments	yes	Employed Practice manager
Blair Practice	Inner city. Many unemployed residents.	2	~5000	Most in 1 <sup>st</sup> (most deprived) quintile.  >half of patients are living in areas defined as the 15% most deprived.	<6 all working full time	no	Employed Practice manager
Sutherland Practice	Rural village. Large retired population.	1	<3000	Most in 4 <sup>th</sup> quintile.  <10% patients are living in areas defined as the 15% most deprived.	<6 one working part time	yes	Practice management done by partners

The age profile of each Practice population is shown in chart X, compared to data for Scotland. Blair Practice has a higher proportion of young patients (<45 yrs) registered than the other two practices and Sutherland Practice has a slightly higher proportion of patients >75yrs than both practices and Scotland.

**Figure 9 Age profile of each practice compared with all Scotland**



(source: ISD: GP Practice populations (166))

### ***Davidson Practice***

#### ***Davidson Practice physical environment***

Location. The Practice is on the main street of the town co-located in a new building with primary care community health services. It has a designated car park and a pharmacy close by.

Patient Areas. The reception area is entered via an automatic large glass sliding door and is a large modern spacious area, full of light and well maintained. There is an electronic touch screen where patients can record their arrival for their appointment near the reception desk. The practice has a suggestions book at the reception desk that regularly has suggestions, and complaints written in it. There is a large, open, curved desk which the

reception staff sit behind. The waiting room is separated from the reception desk by a partial glass wall. It is large and airy with chairs in neat rows.

Every time I visit the Practice to conduct fieldwork at least one receptionist is sat behind the desk and most often two. They are always occupied at their computer or attending to patients in person or on the phone. Everything is always immaculately clean and ordered both in the public and non-public areas of the practice.

One wall in the waiting room has scenic photographs, one has a plasma screen television that broadcasts some snapshots of TV programmes and some practice information and health related advice. Near the back of the waiting area there is a play area with a large number of toys.

There are two very tidy notice boards on the other walls along with a patient leaflet holder. The first notice board has three posters relating to patient feedback. The first poster provides details of how to provide suggestions and complaints to the practice; the second is from the practice's patient participation group seeking patients' comments and new group members and the third is informing patients that they may receive a national patient survey in the forthcoming months. In addition to this a comments book is placed at the beginning of the reception desk although it is not well signposted for patients. There are 8 other posters relating to a variety of topics: photos provided to Practice for display from local photo group; community helpline for transport to appointments; physiotherapy, opening hours of Practice over festive period; stop smoking services; ice hockey; "how to book, check or cancel an appointment with GP or nurse at any time night or day to".

Doctors and nurses come into the waiting room to call patients through for their appointments. All consulting rooms are large, clean and tidy. Each nurse also has an allocated consulting room and in addition to this there is a minor injury/illness room equipped to deal with relevant cases that need to be seen as emergencies.

Staff areas. Administrative areas are behind keypad locked doors. They are also always very clean and tidy and designated areas are used for specific tasks such as; answering phones; typing patient letters, dealing with claims, organising appointments and managing data related to the QOF, summarising notes and dealing with insurance claim requests, medical assessments and referrals; dealing with queries to and from hospital and acting on GP instructions given through the electronic patient record and management system.

All administrative staff place their coats and bags in the locker room. No drinks or food are ever seen on desks. A radio plays at a low volume in each of the two administrative offices. All staff, including GPs within the Practice and the community services located above the Practice take their breaks away from their desks in a large well equipped staff room upstairs in the building. In addition to the staff room there are staff changing rooms equipped with toilets, showers and lockers.

Staff appearance. Staff are always dressed smartly. Male GPs wear shirts and ties, female GPs wear work dresses or skirts/trousers and tops. Nursing staff wear the national uniform or tunics and trousers depending on who employs them (NHS or practice). Administrative and reception staff are all smartly dressed in black trousers, work issued blouses and cardigans, and formal shoes. The office manager and Practice manager wear suits.

### *Davidson Practice organisation*

Patient access. This Practice feels business like. It has its own interactive website that patients can check, cancel and book routine appointments 24 hours a day; ask questions/make comments to the Practice and find information on common conditions, how to access Practice services, Practice newsletters and minutes from the practice's Patient Participation Group (PPG).

There are 8 telephone lines to the Practice and patients have access to a repeat prescriptions line and a line through which they can make appointments 24 hours a day/

seven days a week. Patients are given options when they ring to either dial one for a medical emergency; two to speak to a receptionist and three if they wish to book, check or cancel a routine doctor's appointment. It is a big Practice with four staff each morning and three staff each afternoon fully dedicated to answering phones.

GP clinic times are between 06:45-08:00; 08:30-10:30 and 14:00- 18:00 five days a week. Nurse and HCA clinics are provided 08:30- 17:00 with two early morning (06:45 starts) and one evening (until 18:00) clinic being provided. The Practice leaflet tells people that appointments before 8am are pre bookable only, although the website makes no reference to the restricted access to this service. The Practice manager told me that these are the practices extended opening hours and are designed for patients who work and cannot attend the Practice during work hours although they cannot restrict it to this patient population.

Interactions with patients. Staff are instructed via a protocol "Booking message slots and GP appointments" to not offer same day appointments. They have to check with the patient that they need seen that day and only when this is confirmed should they offer a call back from a triage doctor which may lead to an appointment if deemed necessary by the GP. This protocol also instructs staff to give no confirmed time of a call back as this may differ depending on workload of GPs. Patients that call in and wish an appointment with a particular doctor can often wait at least 3 days. Staff are also often observed apologising to patients for the lack of availability of non-urgent appointments with any doctor for up to three days in advance.

Patients who come to the reception desk are greeted in a consistent, relatively scripted way with "hello, can I help you?" Staff are business like in their communication with patients - professional, courteous and efficient. Interactions on the phone and at the desk are brief and to the point. There is very little social chat between patients and staff. There is a

guidance document on how staff should best manage telephone discussions with patients. This states the responsibilities of staff to stay calm, polite, to offer assistance and not to argue with patients. Specific phrases are advocated for use within the “booking message slots and appointments” protocol.

Staff behaviours. In all working areas of the Practice staff always appear to be very focused on their work. There is an evident division of roles between reception (front desk) and administrative staff (back office) with only a few who work in both roles. Very little social interactions take place between individual staff in any of the areas outside of tea/lunch breaks unless about work although they all appear to “get along” with each other.

Management. The office manager has a desk in one of the administrative offices with other staff. She oversees the work being undertaken by team members and is sought out relatively infrequently by staff for advice. The practice manager is also a visible presence in these areas. Although she is located in another office, she frequently walks through and spends time in the office areas. She has a very calm and professional demeanour and always talks quietly with staff and seeks feedback on how their day is going. She also informed me in the first few visits that she has a phone in her room that lets her monitor how quickly external calls are being answered and in addition to this she routinely audits the quality of telephone interactions and time to answer calls.

GP and nurse activity is relatively removed from the areas where administrative staff work. The two staff groups (clinical and administrative) seldom interact face-to-face. Most communication between clinical and non-clinical staff occurs via the electronic patient and practice management system – Docman. GPs take their morning break in the staff room but this tends to be an hour after the administrative staff have taken theirs. GPs tend to only come into the administrative work area to collect their mail or to seek out help or advice from a specific person.

There is an induction pack for all new administrative and reception staff and nurses. It indicates that all staff are allocated a mentor and introduced to how the Practice runs, Practice equipment and tasks, Practice staff roles and details of all staff who use the building including the community services located above the practice. There is written guidance for most administrative roles and a checklist to record that all tasks and use of equipment have been taught. There is also a written assessment at the end to be completed and returned to the Practice manager on completion of induction along with staff's personal employment details. Staff are informed in this process of their requirement to take part in regular reviews of their performance and ongoing training and development.

*Patient Information.* This Practice has a wide array of leaflets that are available on request at reception desk and on their website, which is advertised on nearly all the leaflets. The Practice leaflet given to newly registered patients is glossy and sponsored by local businesses. On the front it details phone numbers for appointments and prescriptions, email, fax and NHS 24 phone number. It includes information about services provided by the Practice. Other leaflets in this pack include carers identification and referral form, costs and arrangements for non NHS services, Practice nurse services, how patients medical records are used by the Practice and other agencies, role of the receptionist, making an appointment guide and repeat prescriptions.

### *Davidson Practice meetings*

A number of routine meetings take place in this practice. The GPs informally meet at 11:30 in the staff room each day. They discuss patient concerns and cases they want another opinion on, discuss workload while they sign piles of prescriptions.

*Administrative meetings.* Administrative staff (reception and office) meet with the Practice manager and office manager monthly to discuss their workload; salient aspects of Practice performance such as how quickly the phones are being answered; patient feedback about

the service provided by them as a group; staffing issues; staff development and new working arrangements such as new policies; sharing of learning from recent significant event analyses and implications for how the administrative staff work.

Partners' meetings. There is a practice meeting of all partners each month chaired by the practice manager. They alternate each month between a longer evening meeting and a shorter early morning meeting. This meeting focuses on the performance of the practice, ongoing activities, workload and resources; operational business related items; partnership agreements; service development e.g. considering new ways of delivering services, considering purchase of new equipment etc and specific concerns/suggestions raised by staff or patients. The membership of this group is all partners, practice and office managers and the senior nurse. They also meet every 2 years to strategically plan the future of the practice.

Nurses' meeting. The Practice nurses meet as a team with the senior practice nurse monthly and discuss operational nursing issues, Practice improvements and changes and learning from significant event analyses or from external communications.

Significant event analysis. Analysis of significant events over the previous 2 years indicates that significant event analyses meetings are also routinely held by the practice throughout the year and take place soon after an event takes place. While action plans are evident there is little evidence recorded to indicate if actions actually took place. In addition to these learning events medical staff take part in running tutorials for other staff and trainees.

## ***Blair Practice***

### ***Blair Practice physical appearance***

Location. Blair Practice is situated at the end of a street full of betting, charity, cash converter and food shops. The building is co-located with primary care and social services



with a small parking area outside. You can only access the GP part of the building by walking along a small concrete path which is always littered with crisp packets, sweet wrappers and beer cans.

*Patient Areas.* The entrance is dark and gloomy and leads into a dimly lit reception area. Straight in front of you as you enter are 2 booths. One is completely covered by a range of haphazardly arranged public notices from local groups and businesses, and the other has untidy stacks of health posters and information sheets.

There is a wooden box in the first booth that patients can place repeat prescriptions in. It has a piece of string attached, with a biro pen sellotaped to the other end. Another, but smaller, shabby cardboard box (about 20 x 20 cm), with “Suggestions” written on it is partially hidden behind the repeat prescription box. It is covered with paper notices – same on all 4 sides: “Help us to help you. Please post any suggestions for improving our service in the box. “Thank you” is written on top of the box with a slot to put comments in. There is no paper to use to write comments and it is not signposted to patients. It is tucked in a corner away from main reception and is quite hidden from the general public as they arrive in the practice.

The open reception desk sweeps the length of one full wall and is normally staffed by one member of staff. They have no touch screen registration tablet and have only in the last 3 years replaced using post-it notes on paper with the use of an electronic document processing system (Docman).

Behind the reception desk is a frosted glass partition. Normally 1 reception staff member sits behind here answering calls and processing repeat prescriptions. Opposite the reception area, behind a full glass wall and door is a waiting room that is very sparse. It is full of daylight but is also tired and drab. One wall has a children’s mural but there are only 2 old toys to be played with. There are very few magazines for patients to read and there is a

small portable television in the corner but is very rarely switched on. Health care staff come through to this area to call patients through for their appointments.

There is one notice board in a corner of the reception area and four further notice boards in the waiting room. All notice boards appear very cluttered and disorganised. There are also numerous posters sellotaped to the doors, walls and reception desk. Most posters in reception area relate to health and social issues however there are others that relate to local community clubs, children's organisations (Scouts, Boys Brigade etc) and some are local business adverts.

One notice board in the waiting room is split into three sections: "patient", "notices" and "social". Although this differentiation is made with headings posters are not necessarily arranged in accordance with this. "Patient" notices relate to the Practice being open late on a Monday; policy for consent to treatment of a child, boys brigade, celiac disease symptoms and stroke – when to suspect it and what to do. The next section headed "Notices" has information about what to do if evicted for not paying rent – Shelter can help, needle exchange service details, alcoholics anonymous contact and meeting details, local initiative about wastage of medicines. Posters placed under the heading "Social" include a diabetes research network looking for participants, information about the need to take own medicines into hospital, local Zumba fitness, local music and dance group, befriending service, provision of local courses for increasing chances of employment.

The second notice board in the waiting room entitled "General Notices" has a variety of information. This includes chronic pain services, HIV positive services, couple counselling, drama therapy, armed forces injuries claims, contraception services, support for those affected by alcohol and /or drugs, transplants, hypoglycaemia and driving, weight loss services, peripheral arterial disease advice and chlamydia testing service.

The third notice board also has a wide array of information including support for learning disability carers, cancer, deaf, life limiting illness, cardiac support, polymyalgia rheumatica, Samaritans, free health checks, young persons' counselling, relationship counselling, depression and working for families.

There is a fourth notice board relating to services provided by health visitors. It provides details of clinics for flu vaccines, healthy start services, free milk, fruit and vegetables, parent and child fun activity sessions, fostering, losing pregnancy weight, meningitis, young parent relationships, children and motor impairments, grow well café, visually impaired and car seat safety advice.

Apart from one generic NHS leaflet about how to complain about the NHS which is stored amongst a wide array of others in a reception booth there are no other prompts to patients about how they might provide feedback about their experience of the practice.

Staff areas. Office furniture is a mix of old and new. There are a number of old, ripped office chairs. Problem printers have not been replaced but are instead continually being "fixed" by the practice manager. Staff keep their personal belongings at their desk. Most take regular cups of tea or coffee to their desks. The staff toilet is off the main corridor to the consulting rooms. It is kept locked and all staff are issued with a key. One of the reception staff asked me on my first day to remember to lock it after use as they had "*problems with patients using it to shoot up*". The consulting rooms are bright, neat and tidy with furniture in a state of good repair.

The staff room tends to only be used by nursing and administrative staff. There is a small kitchen with a kettle, microwave and fridge. It has a number of notices asking people to keep the kitchen tidy. Now and again GPs will sit and have a short break with other staff but tend to take their breaks in their own consulting room for the most part.

Staff appearance. The male GPs tend to wear smart trousers and shirts and ties; the females dress smartly in skirts and tops or dresses. The practice manager tends to wear trousers and blouse or dresses. Staff wear work tunics and black trousers. Most tunics look old and worn out. Approximately three quarters of the staff come to work smartly dressed with formal black shoes and hair tied up or short and tidy however the other ¼ tend to wear old worn trainers, wear their hair down, wear lots of jewellery and wear old cardigans over the top of the tunics and back jeans.

### ***Blair Practice organisation***

Patient access Most times when I visit the practice reception staff are seen standing at the reception desk. Some attend to computer related work when not dealing with patients while others stand at the heater and chat.

The practice does not have a website. There are 4 telephone lines into the practice. Patients can only book or change/cancel an appointment by phoning the practice within business hours 8am – 6 pm. Extended hours consist of one GP session until 7:30pm one evening a week. There is a separate line for ordering repeat prescriptions and patients can leave messages on this 24 hours per day. Patients can also email their repeat prescriptions in. All calls into the practice are answered directly by a receptionist. Calls are answered in different ways by different staff with no specific script being immediately apparent. There is no specific written guidance for staff on how to deal with patient phone calls. It is a busy Practice with many patients presenting at the desk as well as phoning to make appointments. They often request to be seen urgently and staff can often offer them an appointment on the day and if this is not possible they ensure the patient gets a call from the doctor at the end of surgery. The practice have a protocol that indicates that GPs desire is to see or speak with patients who wish to be seen that same day on that day and staff should “not under any circumstances tell patient to call back at 0800 the next day.” It also

indicates that patients should be offered an alternative to a doctor's appointment if one is not available such as an appointment with a nurse and that those patients who walk in should be asked to wait to the end of surgery if there are no appointments left. Doctors tend to work through their breaks and outwith surgery time to ensure they call and/or see all patients, including those who turn up late for appointments.

*Interactions with patients.* Patients are greeted warmly by all staff, most often by their first name. The Practice feels less like a business than Davidson Practice. Staff seem to know patients and many patients know each other. Interactions between staff and patients tend to be friendly and informal and staff often engage in social chat at the desk or on the phone with patients. At times patients can be loud and abrasive towards staff and staff are always observed to stay calm and when appropriate, firm with patients.

*Staff behaviours.* Other administrative staff work in offices that are behind locked keypad doors. Most staff undertake all duties however a few do not undertake repeat prescriptions work through choice. A number of them told me that it is complicated and they are frightened to make a mistake so have not taken it on. One receptionist takes a coordinating role and makes up the staff rota. GPs frequently come through to the desk behind the reception desk to seek clarification on appointments made, requests or notes placed by receptionists in Docman and to leave prescriptions and notes for staff. The offices are cramped and cluttered and one desk is within the communal staff room. There are very few desk tidies for paperwork and supplies, and prescriptions and post it notes appear to lie on desks in unorganised ways. Walls are littered with guidance notes, NHS letters, posters, staff rotas and staff photos.

Staff work at a relatively casual pace with many answering personal texts and phone calls or spending time chatting socially during their work hours. The staff are generally friendly towards one another however at times there can be heated discussions.

Management The Practice manager is bubbly and outgoing. She has limited autonomy to change any aspects of the service because this requires full negotiation with all of the partners. She has a directive style of leadership and leaves lists of tasks for staff to follow every day in order that the Practice can achieve maximum QOF points. She has an office and spends most of her day through there. She does however “check in” with staff throughout the day, covers the phones and reception when needed and takes her breaks with the staff.

Two new staff started and one member left in the time I was in the Practice and the receptionists tell me that while there is a core of staff who have worked there for many years they do not tend to keep new staff for very long but state they are unsure why. There are no staff induction materials and on asking one newer member of staff she informed me that new staff receive no formal induction. Instead they are shown how to conduct key tasks and how to use the computer software and asked to read the protocol folder and thereafter they just learn by watching others.

Significant event analysis. Significant event analysis reports are within a folder kept in the PM’s office. There are only a few and all appear have been undertaken in preparation for a QOF visit by the CHP. There is no evidence that they take place routinely throughout each year. All bar two are dated pre 2010 and appear to have been undertaken individually by each GP rather than collectively with other team members.

Patient information. There is a plethora of patient leaflets lying on the booths at the side of reception desk. There is a Practice leaflet for new patients. On the front page there is a line drawing of the practice. Inside it states “you have a right to good health care delivered efficiently and courteously, and if you feel we have not done this, please tell us. The vast majority of our patients use the health service responsibly, and we look forward to continuing this relationship of mutual respect”. There is then information about opening hours – (08:00-18:00 and one late evening session), how to provide feedback if not happy

with the service, how to make an appointment and to expect when making an appointment to see a particular doctor that the same day may not be possible, how to register with the practice, how to arrange a home visit, how to obtain repeat prescriptions, list of all staff and their relevant qualifications, table of opening hours and clinics, advice on management of common illnesses, statement indicating that they should not take drugs as they are bad for their health and social well being, telephone numbers for local hospitals, NHS 24, benefits agency , social work, couple counselling , Women'sAid, Alcoholics Anonymous, Childline, drug problem service and Samaritans and lastly an explanation of age of consent. There are key messages noted such as drugs - "you deserve better, just don't take them."

### ***Blair Practice meetings***

*Clinical Meetings* The Practice have a meeting every Tuesday between the GPs, health visitors, district nurses, Practice nurse, Practice pharmacists, Practice manager and a reception team member. This meeting is focused on patients and/or families who are causing concern or have specific and significant needs most of which relate to child protection or mental well-being of patients. At this meeting all clinical staff all are given time to raise patient /family issues and the Practice manager contributes to these discussions with knowledge of patients' behaviours or circumstances or their records relating to test results or GP /clinic attendance records.

*Partners' meetings*. There are no routinely held partners' meetings. The Practice manager told me that she meets with the GPs when required and they don't minute such meetings.

*Administrative meetings*. There is a monthly staff meeting run by the Practice manager however they are frequently cancelled. The GPs take it in turn to have a representative present at that meeting. It is often cancelled due to other priorities such as the clinical caseload of the GP. The focus of this meeting is on a) working conditions such as tea breaks, annual leave allocation and keeping the kitchen tidy and on b) ensuring work processes

meet required standards for example processing repeat prescription requests, investigation results and maintaining electronic patient records. Minutes of these meetings are produced and stored in a folder. There is a sign off sheet to confirm that everyone has read them however most times the sign sheet remains largely incomplete.

### ***Sutherland Practice***

#### ***Sutherland Practice physical appearance***

The Practice is a spacious modern building set at the end of a main road of a rural village.

*Patient Areas.* It is a bright, modern, inviting building entered via a sliding door. There is a metal box mounted on the wall with a “Comments” label clearly visible. There is no obvious place where patients can access paper and pen to write a comment however.

The large waiting room is directly opposite the large reception desk. The radio plays softly in the waiting and reception areas. It is full of daylight and chairs are rowed neatly. Staff sit in the office behind the reception area at computers. Like Blair Practice, this Practice is also relatively “low-tech”. There is no touch screen registration system, staff either greet patients by name as they arrive and ask them to take a seat or get up and speak to them at reception. Doctors and other health care staff come through to the waiting room and call individuals to come to the consulting room.

There is a small area in the waiting room for children with a variety of toys. On the walls hang a local artist’s paintings for sale. There is a screen with posters relating to services provided and the research activity of the Practice neatly arranged. One notice on the notice board indicates how patients can give feedback to the practice. It informs patients of what to do if they are unhappy with the service they have received. On a table at the back of the waiting room sits a set of folders on a table with a wide array of health and health support information leaflets such as: female survivors of sex abuse helpline; confidentiality guarantee; The NHS and You , what you can expect from us and what we expect from you



(NHS Scotland) how to see your health record advice; local services – voluntary, community, social, disease specific voluntary services and self-help group information; specialised health services e.g. learning disability liaison nurse to help such people with hospital admissions and attendances; managed network for dementia etc.

*Staff Areas.* There is one main administrative office which is accessed from a separate corridor to the consulting rooms. Although there is a door with a keypad through to this corridor it is always wedged open. Off this area is a large Practice manager office and store room. Further along the administrative corridor there is a well-equipped staff room, bathroom with shower and changing room and another couple of consulting rooms that are routinely used by community staff to see patients.

All staff areas are kept very orderly and clean. There are files mounted on the walls for the processing of prescriptions and mail etc and no paperwork is left lying on desks. Staff leave their coats in the changing room.

*Staff appearance.* They are all smartly dressed. Male GPs wear shirt and tie and females wear dresses or smart skirts and tops. Administrative staff wear black skirts or trousers, work blouses, work issued cardigans and formal black shoes. Guidance for Practice is all stored electronically and the walls are free from clutter.

### ***Sutherland Practice organisation***

*Patient access.* The Practice does not have a website; patients can access appointments in person or by phone. The Practice is open 08:00 - 12:00 and 14:00 - 18:00, four days a week with one half day. Extended hours are from 07:30- 08:00 two mornings a week. There are 2 lines into the Practice and staff take it in turns to answer calls while they undertake other tasks. The Practice has no Practice nurse so much of chronic disease management is undertaken by the GPs. The Practice buys in some Practice nurse time from the district nurse service.

There is no specific protocol on how appointments should be offered although there is a statement in an advanced access protocol, *“we aim to see all patients who require an urgent appointment on the same day and non urgents within 2 working days”* Patients are routinely offered an appointment on the same day as they call. Practice staff can also book patients in after surgery sessions if they feel the patient needs to be seen that day. The Practice closes each lunch time however sometimes GPs will work part of this to complete a morning surgery or to conduct house-calls. Patients can request repeat prescriptions by email or by handing them in to the chemist or the surgery but cannot phone such requests in. There is a post box outside the Practice for this in order that repeat prescriptions can be requested outside surgery hours. One of the receptionists told me during an observation that they had stopped taking repeat prescriptions by phone as it led patients to think they could order and collect them in the same day and they could not meet that demand. (Sutherland Practice observation 07/09/12)

Management. There is no practice manager, both partners share this responsibility. The part time GP sits in the office off the main area for three or four sessions per week and routinely interacts with the staff and will answer calls and assist at the reception desk when needed. The practice feels similar to Blair Practice in that staff know most of the patients however it is a far less busy practice. There are normally two administrative staff on duty but there can, for a few hours a day, be only one on duty.

Administrative staff are not allocated to specific tasks, but negotiate between themselves what needs to be completed each day. GPs and staff engage with each other frequently throughout the day about their work and patients’ needs and they all act supportively to one another. They also all (GPs and staff) socialise outside work together on a regular basis and always seem happy at work. Local pharmacist staff come in and talk with staff and although staff are friendly, they always quickly return to work. Staff take cups of tea or coffee at their

desks. They have their morning tea-break in the front office. GPs tend to join them at that time and are as likely to make the tea as the staff.

There is no induction pack for new staff. One of the GPs told me this was really quite unnecessary as there is not a routine turnover of staff. They guide the Practice of everyone through numerous policies on the shared IT drive and by reinforcing adherence to processes at staff meetings or in the event a process has not been completed appropriately.

*Interactions with patients.* Interactions between staff and patients are informal. There is no protocol on how patients should be dealt with on the phone or how the phone should be answered. Staff all answer uniformly by stating good morning/afternoon, the Practice name, [name] speaking and “how can I help you”. Following this, exchanges appear to be friendly with both patients and staff often asking after each other’s relatives and the person’s overall well-being and although staff are friendly, polite and courteous they do not (like in Blair Practice) linger with patients. The senior receptionist told me that they tend not to sit at reception as they find patients “use it as an excuse to stand and chat and it distracts us from getting on with our day’s work” (Sutherland Practice observation 20/09/12)

*Patient Information.* There is a practice leaflet for newly registered patients. It has a line drawing of the Practice on the front and is a poor photocopy version with some duplicate pages in it. It details the opening times of the Practice and the availability of emergency appointments daily after the normal consulting times but within Practice opening hours although it is hard to make sense of this information due to how it is presented. Telephone and fax numbers for the practice are then provided followed by a list of staff names; list of clinics and their times; average length of time for test results to be back with the practice; how to label and give the practice a sample; extended hours times and who they are designed for (“patients who work and cannot attend during the day”). Also included are details of how to arrange repeat prescriptions; numbers to call for medical help outwith

practice hours; criteria and process to be followed for home visits; geographical boundaries of practice; how to register with the practice; private services provided; access for disabled and patients' choice regards seeing students while in the practice. They also inform patients that they can make a comment about the service by placing a note in their suggestion box or telling the practice manager although there is no indication in the leaflet who the Practice manager is. It also indicates that if a patient has a complaint about any aspect of the provision of medical services they should put it in writing to the senior GP. This is followed by a section on patients' rights and responsibilities – "we are committed to giving you the best possible service and believe the only way to achieve this is by working together. Staff will treat you with courtesy and respect at all times, and ask patients to treat staff accordingly". Patients are also asked to let the Practice know if they cannot keep an appointment and that the practice will not tolerate violent or abusive behaviour. Further information includes details of the practice requirement to hold health data but keep it confidential; contact numbers of local hospitals and chemists and other health care teams; details of the practice's participation in Medical Research Council's General practice Research framework and the implications of this – sharing of anonymised data; approach patients to seek their participation in studies and their right to not take part and how they can let the Practice know their wishes. In addition to this patient leaflet the Practice keep numerous other health related leaflets provided by a variety of services in a cupboard in the administration office, all neatly ordered.

### *Sutherland Practice meetings*

Partners' meetings. There are no formal partners' meetings; the partners told me that they normally agree things between themselves without the need for formal meetings.

Staff Meetings. Fortnightly meetings take place between the GPs and administrative staff. They take place during lunch time when the Practice is closed and diverts its calls to a

neighbouring practice. They are very rarely deferred. The meetings focus on discussing how things have been in the practice, any issues and developments that all need to be aware of, upcoming training days and staff training needs and any research that the Practice is considering taking part in. Minutes are taken at each meeting and the agenda is left on the shared drive on the computers for all to contribute in the week running up to the meeting.

*Significant Event Analysis.* The Practice routinely undertakes significant event analysis meetings. The results of these are recorded in the shared drive of the Practice computer system. Although there are often identified actions, like the other two cases there is little evidence to indicate if these are subsequently implemented. The GPs also routinely take MDDUS significant event analysis reports from other anonymised practices and use these to support learning at staff meetings

## Conclusion

This chapter has outlined the volume and range of data collected in each case and provided a description of the context of each practice in terms of their respective sizes; populations they serve; their physical environments and how they conduct business.

The context of each Practice is important in this realistic evaluation where it is understood that it is intrinsically linked to how likely a Practice is to change how they work in response to patient feedback. Key differences between the contexts of each practice are summarised here before detailed discussions of how context appears to influence the use or impact of patient feedback are discussed in the two subsequent chapters.

Davidson Practice is far larger than the other two and serves a large population of relatively affluent patients. Staff are very aware of and conduct their roles in accordance with expected standards and protocols. It has strong leadership and management and partners and staff work in very structured ways with most activities guided by rotas and guidelines.

Time is allocated throughout the year to allow all staff groups to meet to consider the issues they are facing, changes that are needed and so forth. Patients however appear to have significant waits to see doctors of their choice and a considerable amount of time and effort are spent trying to address this.

In contrast, the other two Practices are smaller, less structured and patients appear to have easier access to appointments with their preferred GP in both. Blair Practice is a very busy practice with GPs rarely stopping to take breaks during their work day. A number of patients display quite challenging behaviours at the reception desk and things can become quite heated at times. The practice is however far less protocolised and “bend the rules” for patients on a frequent basis to ensure for example, they get their repeat prescription or get seen for appointments that they either missed or turned up late for. Although a GP attends the administrative meetings and one administrative staff member attends the clinical meeting the focus of such meetings is predominantly on operational issues and working together to keep patients and families safe (socially and medically) rather than how the practice may or should change the ways in which they work. Like Davidson Practice, doctors and administrative staff tend to work relatively separately and although interact during the day this tends to be just briefly as doctors are passing through the office areas or like in Davidson practice via the Docman system.

Sutherland Practice is smaller than the other two practices with a slightly older population. Practice management is undertaken by the Partners and similar to Davidson Practice they ensure time is set aside for staff to consider the quality of the service and how it can be improved. Different from both other Practices however, such discussions take place directly between all of the administrative team and the GPs and are not solely confined to meetings. They are a far quieter than Blair Practice and have a patient population with far less

deprivation. They therefore do not appear to spend as much time discussing and managing risks patients and their families are facing as Blair Practice does.

It can be seen from this examination of the practices that they all face different pressures and that Davidson and Sutherland practices have more formal structures and processes designed to manage practice activities and quality improvement than Blair Practice. These are only the characteristics of the practice that are observable to the outsider however.

Other contextual factors more related to the Practice's values and opinions of patient feedback also have the potential to shape the actions of individuals and teams. The next chapter therefore first focuses on the ways in which each Practice gets feedback; what patients say about the Practice; how each practice views patient feedback and lastly what they do with such feedback within the Practice. These findings will then be compared with assumption 1 in the programme theory and stage 1 mechanism (reasonings and actions) in the CMO to consider the extent to which current assumptions of how feedback is or could be used in General practice explain what actually happens in practices. The final findings chapter will then consider Stage 2 and 3 of the CMO in detail, exploring how and why practices go on to change practice in response to patient feedback and what appears to influence the likelihood that change efforts result in discernible improvements.

## **Chapter 5 Stage 2: Findings (a) Gathering of formal patient feedback and deciding to act on it**

### **Introduction**

All Scottish general practices receive patient feedback in three main ways. Patients can provide positive or negative feedback directly to practices in person during consultations or at the reception desk, in writing, or through thank-you cards and gifts. For negative feedback, practices are required to have a formal complaints procedure, although such feedback is mostly informal and does not turn into a formal complaint. Two more formal ways of receiving feedback involve surveys. Practices receive a bi-annual report from a centrally administered patient survey measuring experience and satisfaction at practice level as part of the “Better Together Patient Experience Programme” (46). GPs are also required as part of the appraisal process to use accredited surveys every 5 years to gather evidence of patient feedback about their care. These surveys cover both practice processes like access, and feedback on experience of care within consultations with the individual GP. More variably, practices can invite or facilitate feedback in a variety of ways, by convening a patient participation group for example.

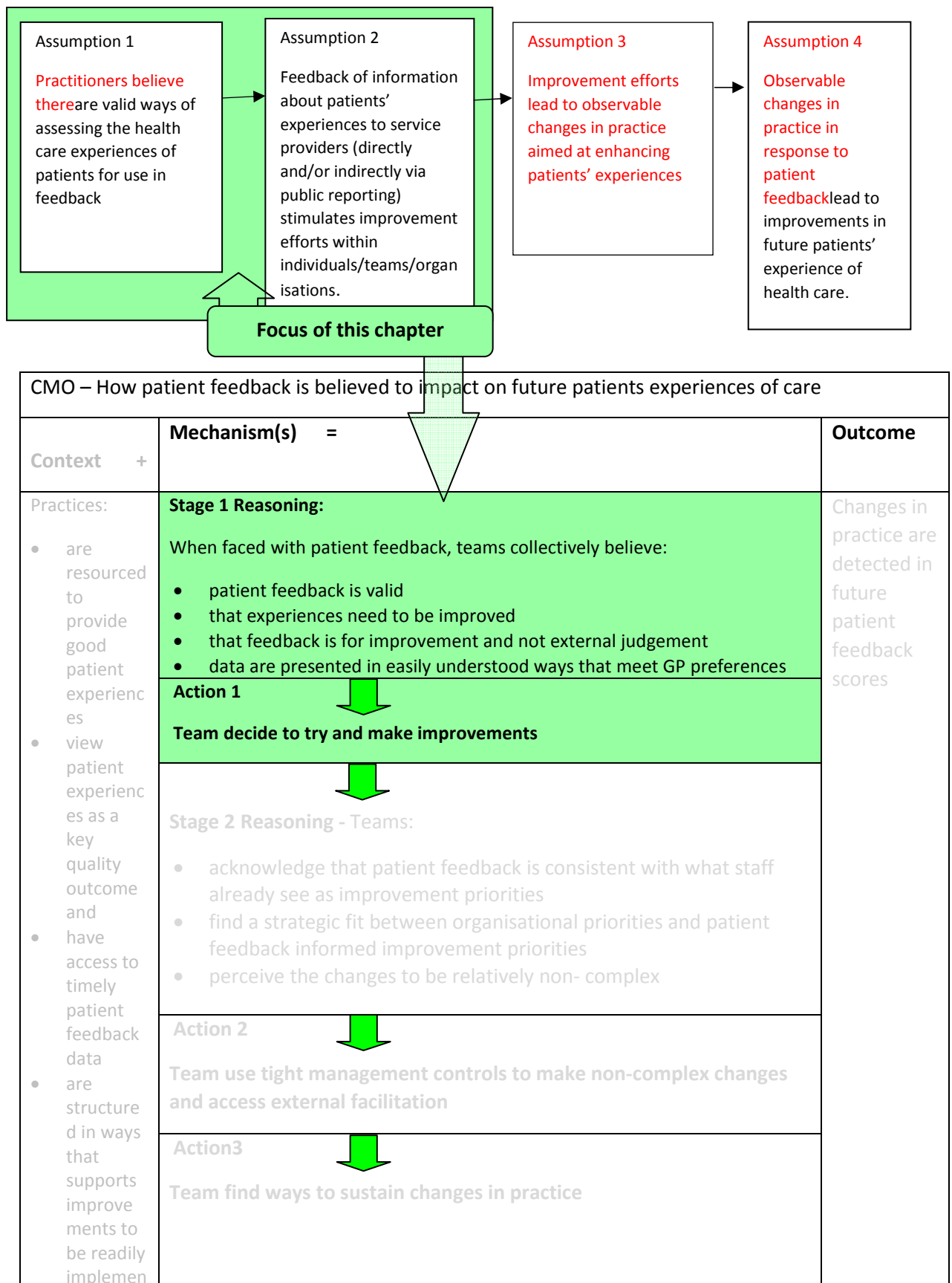
This chapter focuses on research aims 1 and 2 depicted in Box 1 overleaf. Realist evaluators accept that context is complex and many mechanisms can be operating at one time and this was indeed the case within these three case studies. The role of the realist researcher however is to identify the contextual factors and mechanisms that appear to most significantly affect outcomes. This chapter therefore seeks to explain practices’ perceptions of various feedback mechanisms, detail the ways in which they gather feedback and explain how and why they appear to respond to formal feedback when it is received.



**Box 1 – Research Aims****Research aims:**

- 1. Explore how practitioners working in general practice gain access to, perceive and respond to patients' experiences of healthcare.**
- 2. Investigate how patients' experiences of healthcare are and can be used to improve GP services.**
3. Identify the strategies/approaches that appear to be useful in stimulating changes aimed at enhancing patients' experiences of GP services.

Both the refined programme theory and the proposed CMO (both first introduced in the methods section – pages 48 and 49 and reintroduced here) were used as the theoretical framework that guided data analysis. They are presented again below to highlight the specific elements that are discussed in this chapter. The focus is on programme theory assumptions 1 and 2 and these are considered more fully by comparing the empirical case study findings with the contextual factors and Stage 1 mechanisms (reasoning and actions) detailed in the proposed CMO (see figure 10 overleaf). The chapter first details findings from each case before considering the cross case commonalities and differences. Chapter 6 shifts the focus onto research question 3 and critically review programme theory assumptions 3-4 and mechanisms 2 and 3 in light of case study findings.

**Figure 10 Focus of Chapter5**

<div>ted</div> <ul style="list-style-type: none"><li>• have access to data that are capable of detecting small changes in patient experience</li></ul>		
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## How the three practices gathered and viewed patient feedback

All practitioners believed that patients' experiences of their care and service were of some importance. Views of patient feedback methods and the range of ways feedback was gathered and differed across the 3 cases (see Table 12, page 121).

Davidson Practice believed they had a very articulate patient population that the practice perceived to be more critical than most because of the large amount of negative feedback they received. They also thought it was important to demonstrate that the practice was willing to hear patients' views and collected information in a number of ways, including establishing a Patient Participation Group (PPG) in 2005. Blair and Sutherland practices only had one mechanism in place to gather feedback beyond the required national surveys - a suggestion box. Blair practice believed that their deprived population with significant literacy, alcohol, mental health and drug problems largely appreciated the service they received. They thought their patient population were generally uninterested in providing feedback and limited in their ability or willingness to do so as a result of poor literacy and "chaotic lifestyles". They perceived that patients preferred to express their opinions of the service or care in person but then rarely pursued this in any formal way. Most believed from the direct feedback they received from patients indicated they were generally happy with the service and as a result, they rarely received negative feedback. They talked for example about the fact that they had not had a complaint in the last two years.

Sutherland Practice, like Davidson Practice believed their population to be articulate but like Blair Practice, they believed their patients to be relatively happy with the service they received. They receive significant amounts of thank you cards and said they routinely received more of these than complaints. They also believed that their practice population was small and close knit and many staff were part of that community. They therefore expected to receive feedback through more informal means if people were unhappy with the service. The GPs in this practice were different to the other two practices in that they paid little attention to positive informal feedback given in person

perceiving it to be unreliable. They thought it possible that patients could appear very grateful and thankful but have a level of dissatisfaction that went unspoken and they had therefore been seeking assistance to establish a PPG.

**Table 12 How practices gathered and viewed patient feedback**

	Formal - Required			Formal – optional			Informal		
	Complaints	National Better Together survey	Suggestion book/box	Website	Waiting room campaign inviting suggestions	Patient participation group	Verbal to reception staff at desk	Verbal to doctor in consultation	Patient booking patterns
<b>Davidson</b>	✓ Seen as useful, allowed practice to investigate and identify if anything needs to improve	✓ Significant concerns over validity of questions, patient sampling, response rates and use of national mean as comparator	✓ Suggestion book prominent at reception desk.  Perceived to be little use- lacks specificity to time and person - limits further investigation Comments left often viewed as “ridiculous” or “unreasonable”	✓ Very rarely used, no specific views regarding its usefulness	✓ Viewed as somewhat helpful in increasing representativeness of PPG but anonymity and brevity of comments limited utility	✓ (est 2005) Seen as a reasonable and helpful way of engaging with patients. Some believe group can “step over the mark” at times	✓ Regarded as a normal feature of general practice and a reflection of a very demanding population	✓ Frequently used by GPs and nurses as an indicator of patient satisfaction. Perceive patients will tell them when not happy	×
<b>Blair</b>	✓ Rarely get complaints; none in previous 2 years	✓ Significant concerns over validity of questions, poor response rates and biased sample responding.	✓ Box is not in prominent position and no paper left to write on. No one ever writes in it.	×	×	×	✓ Patients perceived as being quite vocal, complain at desk but rarely take it further	✓ Staff report that patients usually give positive feedback but will tell staff when they are unhappy too	✓ Booking patterns used by some staff and GPs as an indicator of what patients think of particular doctors
<b>Sutherland</b>	✓ Staff report they receive few complaints, but see them as helpful.	✓ No concerns over validity of survey questions	✓ Box is prominently placed at entrance to practice fixed to wall. No one ever uses it, no clear access to paper and pen to leave comment.	×	×	×	✓ Patients tend to praise service on phone or at desk or thank staff for help	✓ Patients thank doctors but doctors don't pay attention to this – seen as biased feedback	×

## **Assessment of the extent to which CMO is upheld in each practice.**

For each practice this next section explores the context and mechanisms in place and how they affected decisions to act (or not) on feedback and considers how this compares with that detailed in the CMO (see page 118).

### ***Davidson Practice Context***

The structure in each practice was detailed in the previous chapter. To avoid repetition this detail is not repeated in this chapter. Instead, the remaining contextual features in each practice are discussed and the overall influence of structure on mechanisms is considered when findings from each case study are summarised at the end of this chapter (pages 165-170).

### ***Is the practice adequately resourced to provide good patient experiences?***

This is a large practice with a very experienced, practice manager who is highly regarded by the GPs and staff. The practice manager has significant autonomy over administrative and financial aspects of the business. There is a tangible shared desire to continually improve and provide excellent care and teaching opportunities. It is however a practice where most GPs describe in interviews and meetings how busy they are, and how increasingly difficult it is to meet the demands of patients while meeting the requirements of their contract.

There was a full complement of administrative and nursing staff when fieldwork began and staff appear diligent and professional in their approach to work. There were increasing concerns about limited GP resource however. The practice manager kept track of available appointments and their report indicated that between 2010/2011 and 2011/12 there was a 13% reduction in the number of appointments available from partners; 33% reduction in locum appointments and 20 % reduction in GP learner appointments. This resulted in an overall 17% reduction in available medical appointments.

### *Does the practice view patient experiences as a key quality outcome?*

Most staff believe patient feedback to be very important.

*"...the important thing is that we have a variety of means of encouraging feedback .... there's a culture that encourages feedback within the practice and that in fact we are seen to do something with that feedback. ..."*(Davidson Practice GP16)

Most however have some reservations of how feasible it is for patients to accurately evaluate care or treatment quality.

*"What I find difficult is patient surveys and patient groups making a comment, a genuine reflective comment about the quality of care that the population as a whole gets because I don't think they really understand how that care is delivered."*(Davidson interview, GP 18)

A minority believe that doctors are better placed than patients to know what could and should be changed in practice.

*"...there's a feeling among GPs that we are the people best placed to know how best to run the service...."*(Davidson interview, GP3)

This minority of nurses and GPs prefer clinical outcome indicators believing them to be a more reliable reflection of the quality of care than any form of patient feedback.

The majority of staff believe they have an overly critical and demanding patient population making it difficult to use their feedback as a reliable indicator of quality. Patients are described as middle class and articulate and often referred to as being "spoiled" and very demanding. All staff perceive that patients receive a good service, and many think a better service than provided by other practices, but despite this patients still complain.

*".... I could see the patients here complaining about it. ...I think they are quite spoilt here but I don't think they realise that...."* (Davidson interview, staff 17)



*“..we think a lot of the complaints in the practice are partly because they do get rather spoon fed and we do get quite a lot of contact with them.....there was a feeling that we’re already giving them more than they get elsewhere and that they were just a demanding population.....”(Davidson interview,GP12)*

### ***Does the practice have access to timely patient feedback data?***

The practice regularly gets feedback from their PPG and in their suggestion book they have on their reception desk. The importance of timeliness of feedback in the literature was specifically in relation to the importance clinicians placed on getting survey data back close to when it had been collected. Although when considering the Better Together survey this issue was never raised, GPs were concerned about the sampling strategy employed. They believe it possible that patients who had not recently visited the practice could receive a survey and that this leads patients to base their evaluations on the opinions of others rather than own personal experience.<sup>3</sup>

*“...could be a number of patients who have not actually attended, they’ve not been to the practice but they are filling it in on a general feeling that they have got from discussion with their friends and colleagues or whatever, they are not necessarily filling it in on personal experience....” (Davidson interview, GP4)*

### ***Does the practice have access to data that are capable of detecting small changes in patient experience?***

Most of the patient feedback the practice collects is qualitative in nature therefore cannot be used to measure if changes in patients’ experiences are occurring. The only quantitative data relating to patients’ experiences available to this and the other two practices is the national Better Together survey. This survey is however not undertaken every year and changes to the questions were made before the most recent survey was undertaken thus making it difficult to compare all scores across

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<sup>3</sup> Better Together survey is sent to patients who are recorded as having visited the GP in the last year. It has a screening question that asks patients to not complete the survey if they have not visited the GP practice in the previous year. There is a possibility therefore that some patients will complete the survey when they have not.

time. In addition there are no reports available that indicate the discriminative ability of this survey to detect small changes in patients' experiences. This means that the requirement to be able to detect small changes is relatively unmet in all three practices.

### ***Davidson Practice Mechanisms***

Against this contextual background, mechanisms (reasoning and actions) in response to patient feedback were not consistent. They were dependent on both specific contextual features and the nature of the feedback itself. Four examples of feedback are now used to detail the differences in how the practice responded to feedback from 2 main sources - the Better Together survey and the PPG.

#### ***Davidson example 1 - Better Together survey data do not lead to new improvement activity being stimulated (although various related improvement efforts were already underway)***

The GPs received the survey data from their practice manager at their regular practice meeting. Results relating to access to an appointment with a patient's preferred GP was statistically significantly lower than the national mean.

#### **Mechanism (Stage 1 reasoning)**

##### **Feedback is believed to be valid**

The validity of the Better Together survey results were generally seen by GPs and the practice manager as being compromised by a range of variables. Response rates were of concern for some staff.

*"... there was such a poor response rate...I didn't think it was terribly helpful but the most disappointing I suppose was the response rate..."*(Davidson interview, GP16)

Survey scores (from any survey) were thought to be skewed by the types of people likely to respond. Most believed that only people who had negative things to say responded to surveys while a minority believed the opposite. These concerns had led to a collective belief that results from this survey were not a true reflection of the service patients received and were neither valid or helpful.

*“I mean you[the Better Together survey results] didn’t really refer appropriately to the way service was delivered in this practice..... So it is, my view is that that was not at all helpful. I don’t think I am alone.” (Davidson interview, GP16)*

Many GPs also believed that the Better Together survey questions were worded in ways that elicited and encouraged negative ratings.

*“... the way the questions are worded, there’s a real emphasis almost on the patients to gripe and probably mostly when we see the results we think that’s not fair, I, I don’t think that’s true, ... the reality of what they are suggesting isn’t true, you know that it is almost false information that’s being fed back to us”(Davidson interview, GP 3)*

### **Experiences are seen as needing to be improved**

Staff generally believed that they provided a good service and GPs considered that they performed well in comparison to similar sized practices. This also led GPs in particular to question the validity and credibility of the Better Together survey data. There was however a shared understanding amongst staff that patients did experience delays in getting an appointment with their preferred doctor but this was perceived to be somewhat inevitable in a large practice as opposed to something that could be improved on. Reception staff were seen on the phones apologising to patients for such delays and they talked with each other about how frustrating they found this. Access to specific doctors was also frequently raised in PPG meetings and doctors reported in interviews that this was a common statement they heard from patients directly. Nonetheless this tacit knowledge of access problems along with survey scores indicating poor experiences acted like

a filter through which feedback had to be passed before assessment of the need for improvement was made.

Firmly held beliefs about the lack of validity of survey scores and the unlikelihood that they could ever satisfy their “demanding patients” combined with a belief that the practice probably provided as good if not better service than other practices to lead staff to attribute their low survey scores to patients’ unrealistic expectations and demanding behaviours rather than indicating a need to change how they organised appointments. The current appointment system was in fact believed to have to be structured the way it was because of patients’ unrealistic demands.

*“GP 11 – “we are so consumed with on call we have little time for routine appointments”*

*Staff14- “yep”*

*Everyone sighs and [chair] moves on. The GPs all look resigned to fact this is an ongoing problem. They have all told me there are problems with appointments and their demand for emergency appointments was overwhelming and largely unnecessary, with many people attending with issues that could have been seen at a later date. They essentially saw it as a thorny issue unlikely to ever be fully resolved.”(Davidson observation notes 19/07/12)*

*“....we will never be able to saturate demand on a, you know, an immediate basis, it just won’t happen, it is just not possible...” (Davidson interview, GP16)*

### **Feedback is for improvement and not external judgement**

The majority of GPs believe that Better Together was a tool designed for judgement because some of the access questions were used to determine part of the payment under the Quality and Outcomes Framework (QOF) of the GP contract.

*“you get irritated and frustrated because you are financially penalised for it and that just makes you disengage with the process and makes you ...it is just a way of ensuring that there’s less money going out...” (Davidson interview, GP16)*

*“..it seemed to be a way of clawing back points and clawing back money and mainly it just seemed not fit for purpose...”(Davidson interview, GP13)*

Many of them compared it with the practice administered practitioner (e.g. GPAQ, CARE) and practice (e.g. IPQ) based surveys previously undertaken as part of the QOF. GPs preferred these surveys to the Better Together survey, perceiving they provided a better indication of what they needed to improve at practice or practitioner level. Loss of these in favour of the practice level Better Together data was viewed as regretful and making it difficult for the practice to easily understand the specific aspects of practice needing changed.

### **Feedback data are presented in easily understood ways that meet GP preferences**

Although the ease with which survey data can be understood has been identified as an important factor in other studies of survey use it was not raised by staff in this practice. They did however have issues with their scores being compared with national means and some suggested that a more meaningful comparison would be to be compared with similar sized practices or those with similar patient populations. This they believed would allow them to understand how they compared with other large practices dealing with patients they considered to be articulate and demanding.

*“PM - well the first is dire, x % of patients can usually see their preferred doctor and this is y % below national average*

*GP - Well that’s not a useful stat though, would be better if we could have had what we were in comparison with practices our size”*

*Other GPs are nodding and mumbling agreement with this statement.” (Davidson observation notes: Business meeting 19/07/12)*

*Mechanism (Stage 1 action) – practice continued with agreed plans to improve access to GP appointments*

This survey finding was received in a team where it was known there was dissatisfaction with access to GP appointments overall and more so with access to preferred GPs. Nonetheless when they received it, they spent time critiquing the data and had no discussion about how or when they might make improvements. Lack of discussion could however have been because the practice had already agreed for two GPs to redesign the appointment system at a practice development meeting held only a few weeks prior to them receiving this survey report. They had also been working towards establishing a nurse led minor illness service and because GPs were increasingly feeling stressed and working long days in order to be able to manage their workloads they were also considering the need to appoint an additional GP. It could be that collective knowledge of these improvement plans had led the team to not consider doing anything else beyond what was already planned, although this was not brought into the discussion.

*Davidson example 2 - Better Together data lead to improvement activity being stimulated*

Against this same contextual background feedback from verbal complaints and the Better Together survey indicated that patients were experiencing significant delays getting through to the practice on the phone. Responses to this feedback were however very different from those in the example above.

Context

In addition to the features of the context already presented the practice also appeared to believe in this instance that they had the ability to tackle this issue. Unlike the previous example where there was a perception that the practice was doing the best it could, for problems of phone access there was a perception that there were adequate resources to deal with this issue. At the time they received the BT feedback, they had numerous phone lines into the Practice which could be increased, no office staff vacancies and only one person on maternity leave. They also had a

member of staff who was undertaking a management course and was looking for an improvement project.

*Mechanism (Stage 1 reasoning)*

**Feedback is believed to be valid**

Although GPs generally believed the Better Together surveys questions to be biased towards eliciting negative responses again on this occasion this was not discussed. Instead, other sources of data were used by GPs and staff to substantiate the validity of this score.

*“Yes we are getting quite a few complaints, there’s a couple of written complaints I think and then there was a suggestion in the suggestion book and then I think the girls as well had had a lot of feedback when they answered the phone they were getting patients sort of saying you’ve taken ages to answer the phone or whatever. And [practice secretary] had had a few as well just from hospital consultants who were struggling to get through to them because the lines were blocked up. So that’s why we had to do something about it.”* (Davidson interview, staff 8)

In the previous example all staff in the practice had heard of the difficulties many patients had in getting an appointment directly from patients. This knowledge, although known by each practitioner was somewhat brushed aside during the meeting when they debated the validity of patient access survey item scores. In this phone access example, validity appeared to not be questioned because knowledge of there being a problem did not only come from patient feedback. Hospital consultants had complained to GPs and administrative staff about getting through, and GPs themselves had personal experience of finding it difficult to get through to the practice when out of the practice. The validity of these sources of feedback was not questioned.

*“PM – x<sup>4</sup>% of patients said it was easy to get through – y% less than Scottish average- it is our worst result. Now this was done Jan/Feb time and I don’t know if the work we have been doing around manning of phones will have changed that opinion.”*

*GP – what happens if the line is busy? GP – it takes ages to get through, you might get engaged or put on hold with an intermittent beep. I know ‘cos when I call I from the centre, I get on and do other things while I wait, it can take a while.”* (Davidson observation notes, Business meeting 19/07/12).

### **Experiences are seen as needing to be improved**

Personal experiences of GPs and their hospital peers were viewed as irrefutable and stimulated practitioners to consider making improvements. Additionally, most staff perceived there to be personal benefits as well as benefits for patients by changing how they worked. Improving the speed at which phone calls were answered was seen as a way of reducing the number of patients who became angry because of delays and this in turn would reduce reception staff stress. Moreover, GPs were also keen to experience shorter times in getting through to the practice.

These two factors appeared to reduce the influence of the “filters” that previously (as with the appointment example above) had led to strong debates over the validity of the survey scores and the feasibility of being ever able to improve their patient access survey scores. When considering if phone access needed to be improved, demanding patients, skewed data, unfair comparisons and beliefs about how good a service the practice provided were ignored. Personal experiences of practitioners and their peers did instead stimulate the practice to consider change was necessary.

### **Feedback is for improvement and not external judgement**

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<sup>4</sup> Data omitted to protect anonymity of practice



Although the Better Together surveys was generally believed to be a tool designed for judgement this was not raised when results about getting through on the phones was presented to the GPs.

**Feedback data are presented in easily understood ways that meet GP preferences**

The format and comparator used in Better Together was significantly criticised in terms of the appointment access questions, however this was not described as a problem (or discussed at all) when the results from the phone access question were being considered.

*Mechanism (Stage 1 action) – improvement activity was stimulated*

The acceptance that change was needed was made by the practice manager prior to the survey results being shared at the business meeting. She had discussed this with the administrative team and they were in the process of considering how they might resolve the issue when the data were shared with the partners. This proactive approach appeared to be stimulated by a) GPs having experienced delays personally; b) knowledge that hospital consultants had also complained; and c) confirmation of delays from routinely collected call response time data. The practice manager's level of autonomy to manage the reception and administrative components also contributed to her taking this to staff and making collective decisions around solutions without the need for partners' approval.

*Davidson example 3: PPG feedback does not lead to improvement activity being stimulated*

The PPG proposed that the practice introduced self-managed INR testing for patients receiving warfarin therapy.

*Mechanism (Stage 1 reasoning)*

**Feedback is believed to be valid**

Nursing staff deemed the suggestion to not be valid indicating that home testing would contravene regulations governing INR monitoring such as calibration of testing equipment. They believed that introducing this could lead to patients titrating their medicines inappropriately in response to inaccurate readings from home machines. These concerns contributed to a decision that the Practice Manager would write to the PPG member who initially proposed the change to explain why current arrangements for monitoring were necessary. When the patient refused to accept this response, his further attempts to suggest changes could and should happen were viewed as misplaced and inappropriate by staff.

*“...he was given a perfectly reasonable response to it but his reply was “Well no, you just don’t want to do it”. He was told that it is NHS guidelines “Oh but you can change NHS guidelines”. So well perhaps that’s what you should be doing? Don’t bring it up in the group, if you’ve been told it is NHS guidelines and this person was told where to go but still brought it up again at the group” (Davidson interview, staff 29)*

**Experiences are seen as needing to be improved**

Initially the practice nurses and management did not view this as something that needed to change and were content to accept that the service needed to run in accordance with NHS guidelines. A refusal from the PPG member to accept this at face value led to the PPG chair and the practice manager to hold an extraordinary PPG meeting where all could hear how practice based testing affected a patients’ life and hear from the practice nurses about the risks and regulations associated with INR testing.

This on the surface looked as if the practice was willing to consider how patients' experiences of this service could be improved. However on speaking with some members of the practice team and the PPG, this meeting was designed to put the issue to rest rather than seek a change in practice. There was a firm belief that even though practice testing was not ideal for patients, aspects of the context prevented them from working in different ways. Staff perceived that they were duty bound to follow safety guidelines and could therefore not support self-testing. In addition the collective beliefs of staff that this practice provided very good services further influenced staff perceptions of the lack of need to change. They believed that they tried to be as flexible as possible to minimise disruptions to patients' lives and until home testing was as reliable as practice testing there was little that could be done.

#### **Feedback is for improvement and not external judgement**

Feedback from the PPG was perceived by most GPs and staff to be useful for improvement and its intention was not perceived to be for external judgement.

#### **Feedback data are presented in easily understood ways that meet GP preferences**

Feedback from the PPG is predominantly through discussions at their meetings with a practice representative. The PPG was perceived by most GPs and staff as a helpful way of discussing aspects of the service. The suggestion for the introduction of home INR testing was however perceived to be unacceptable. Although not written into any terms of reference there was a general perception held by practitioners and staff alike that patients could not, and should not comment on aspects of clinical care, and that it was only legitimate for them to comment on non-clinical aspects of the service such as waiting times, delays, friendliness of staff and so forth. Additionally this was an issue that was perceived as a personal mission of one member and using the group for personal purposes was contrary to agreed terms of reference.

*“...I do feel that they’re [the PPG] discussing topics that are not suitable for a patient participation group. What they’re maybe bringing up I think is a higher level that’s more NHS [Board name] than a group issue and sometimes they can go on a bit of a personal rant.....”* (Davidson interview, staff 29)

*“...[PPG member] was using the PPG for “his own purposes and that’s not what it is about”*  
(Davidson observation notes, 08/05/12)

These perceptions, along with staff’s concerns over the need to ensure safe monitoring, influenced the decision to initially write to the individual who made the proposal and when further challenged by the same individual, hold a carefully managed meeting designed to lay the issue to rest.

*Mechanism (Stage 1 -no action)– improvement activity is not stimulated*

This extraordinary meeting where evidence for (from the patient) and against (from the nursing staff) introducing self-testing resulted in the nurses agreeing with the PPG member who had raised the issue that patients were at liberty to self-test but the practice could not use the readings to influence their prescribing. At their next meeting the PPG reflected on this response of the practice was perceived by the PPG member who had originally suggested the change as a positive result.

*“It [minute of previous meeting] gave a clear message to others about why this was and what the state of play from the practice was and I for one was surprised at that decision and had not expected the practice to have come to that end , thought they would say a blank no.”* (Davidson observation notes, 11/07/12)

It appeared that showing willingness to seriously consider issues raised by the PPG was as important to this patient as significantly changing practice.

*Davidson example 4: PPG feedback leads to improvement activity being stimulated*

Previous and current survey scores, patients' complaints in the suggestion book and feedback from PPG members all indicated that patients were concerned about a lack of privacy at the reception desk.

*Mechanism (Stage 1 reasoning)*

**Feedback is believed to be valid**

The validity of patients complaints relating to privacy were not questioned per se by the practice. The practice did however challenge the cause of the problem. Patients were concerned about being overheard at the reception desk and the PPG believed that a few small changes could be made to alleviate this. The practice instead believed that they already had adequate provision to ensure patients' privacy and patients just had to use these appropriately. They had a private room that patients could ask to use and a sound barrier at the far end of the desk. Information relating to these arrangements was however placed on a small notice, at the far end of the reception desk and most likely not seen by patients or noticed until after they had talked with a receptionist.

It was expected by the practice that patients who wanted privacy should ask to use these facilities and other patients should stand back from the reception desk while waiting to be seen to afford people privacy. In essence therefore, the practice acknowledged that people's experiences were valid but did not accept that proposed changes to resolve it were necessary.

**Experiences are seen as needing to be improved**

Although a lack of privacy was seen as unacceptable the practice did not readily accept they should or could do anything to improve this and instead patient behaviours when at the desk needed to change. Persistence of the PPG however ensured that it was discussed at a number of meetings until a resolution was reached.

*“PPG member – “Suggestions, one of the major gripes time and time again is the privacy at the desk, can we do something about it?”*

*Practice representative interrupted and said – “well we have done something about this week. We have separated the reception staff PCs to opposite ends of the reception.” (This action had followed previous discussion at a PPG meeting)*

*PPG member- “good and could we do some simple things like the sign that says you can talk in private elsewhere at the start of the desk rather than the end ... Another poster that says queue here please, simple but ensures people don’t walk up right behind you while at the desk.”*

*Practice representative indicates they are uncomfortable with suggestions.*

*PPG member is exasperated –“NO! it is 3 simple things, they do it in [local hospital] and we should see a vast reduction in complaints about this issue and raise our scores in relation to it.”*

*Practice representative says “Yes we can do that.””(Davidson observation notes, PPG meeting, 11/07/12)*

### **Feedback is for improvement and not external judgement**

As mentioned earlier the Better Together survey is seen as a tool for external judgement and this belief tends to make Davidson practice staff somewhat sceptical of its results. PPG feedback and discussions are considered however to be helpful for improvement.

### **Feedback data are presented in easily understood ways that meet GP preferences**

No-one questioned or appeared to be concerned as to how this item score was presented. No-one discussed for example their concerns over a national mean being used as a comparator and no-one questioned the legitimacy of this issue being commented on by patients in the PPG.

*Mechanism (Stage 1 action) – improvement activity was (eventually) stimulated*

The existence of the PPG (context) and its persistence in continually raising the issue (mechanism) eventually led the practice, after six months of discussion, to place a stand before the reception desk to ask patients to stand back to afford others privacy; to place their poster offering a private room in a more prominent position on the reception desk and to create more distance between reception stations at the desk in order to minimise the extent to which patients who were being received at reception simultaneously could overhear each other's conversations.

***Summary of Davidson Practice Findings***

These four examples demonstrate the way Davidson practice responded to patient feedback from four key sources – Better Together survey data, PPG suggestions, their suggestion book and verbal complaints to staff. The findings also highlight that Davidson practice made decisions to try and implement significant changes in most situations despite some divergence from the context and reasoning assumed to be necessary to stimulate a decision to change.

***Context***

The context in this practice was consistent with the context assumed to best support improvement efforts in response to patient feedback in all but one way. It was **well resourced to provide good patient experiences** and when required the practice team were prepared to consider using their resources differently to meet patient requirements. Their agreements to try and implement a number of improvements in response to patient feedback demonstrated that they **viewed patient experience as a key quality outcome**. While the Better Together survey was only completed every two years this practice had established a range of ways of **accessing timely patient feedback data**. Furthermore this practice had regular meetings and a PPG that supported them to consider the changes needing made and how changes were progressing. This latter point will be discussed in more detail in a later chapter detailing how the practice progressed with implementing change. It is impossible to ascertain if the practice had access to **data that are capable of detecting small**

**changes in patient experience.** There is no published evidence thus far on the discriminatory capacity of the Better Together survey. The practice had foregone undertaking local practice level surveys after the introduction of the national survey and therefore only had access to qualitative indicators of experience such as verbal feedback, suggestions and comments and discussions with the PPG. GPs were continuing to undertake practitioner specific surveys that also include feedback about the practice however there was no evidence of their use within practice discussions during fieldwork.

There was however a couple of other features of the context that also seemed to influence this practice team's response to patient feedback. As well as having strong and reliable structures that ensured patient feedback could be discussed this team had a strong commitment to continuous quality improvement. Meetings were very focused and ensured full engagement of all staff in continuous quality improvement by a reliance on full consensus on all proposed changes.

Additionally a commitment to having an active PPG also appeared to support this practice to not forget or to fully consider proposals such as enhancing privacy at the reception desk and changing INR monitoring that were important to some patients but perhaps not the biggest priority for the practice team.

### *Stage 1 Mechanism (reasoning and action)*

The reasoning that Davidson practice staff engaged in was quite different from that proposed in the CMO. All of the GPs and many of the practice staff **did not perceive patient feedback** (from the Better Together survey) **to be valid**. Many perceived that survey scores were negatively affected by the characteristics of their patient population and GPs particularly had concerns about the timing of the survey, sample sizes and how some questions were worded. These concerns acted like a filter through which staff received patient feedback and at times stimulated an initial and short reaction of challenging the credibility of the data. This was however swiftly followed by discussions on the root cause of each issue and if and how it could be addressed.



A recognition and agreement amongst practice staff that **experiences needed to be improved** was a critical step in making a decision to act on the feedback. Often this decision was made after knowledge of patients' experiences from various sources was considered. In all three examples where the practice made a decision to change, the Better Together survey scores were compared with other sources of knowledge such as information from patients during day to day interactions; statements left in the suggestion book, personal experiences of trying to access the practice, comments from PPG meetings and other routinely collected data such as suggestions and call response times and the number of available appointments to judge if improvements were required.

Most GPs and practice management viewed the Better Together **as a tool for judgement** because of its previous association with QOF payments for patients' reports of their experience of access. The practice did however have access to other sources of feedback such as their suggestion book, formal written complaints and the PPG that were viewed as helpful in supporting decision making when improvements were being considered.

Lastly, the Stage 1 of the CMO assumes that before agreeing to make changes (Action 1), **teams will collectively believe that data are presented in easily understood ways that meet GP preferences.**

There were no difficulties in understanding any of the sources of data observed. Preferences for data however were not always met. GPs perceived the comparison of Better Together survey scores with national means as unhelpful and unfair. This led GPs, when faced with survey items scores below the national average to at least temporarily further question the credibility of this survey and to rationalise that they probably would fare relatively well if they were compared with other large practices. Interestingly, the same did not occur when faced with scores above the national mean. The PPG also expressed some frustration when they received anonymous comments in response to their waiting room campaign that asked for patients suggestions for improvements in the practice services. A few comments lacked clarity or sufficient detail to be understood and because of their anonymity, these could not be further investigated.

It is evident from this particular case study that this team made decisions to try and make improvements even when they had concerns over the validity of Better Together survey data, perceived it to be a tool designed for judgement and provided in ways that did not meet GPs preferences.

There was evidence of further reasoning not detailed in the CMO that took place prior to this practice team agreeing to try and make improvements in patients' experience. The team's perceptions of their capacity or authority to make changes and the feasibility that improvements were possible appear to be influential. When the team perceived that change was needed they also considered how capable they were of implementing the change and the likelihood that the changes they were considering would be recognised by patients. When Davidson Practice administrative staff for example, knew privacy was an issue they initially perceived that they were incapable of improving this as the origin of the problem lay with behaviours of patients themselves and initially believed they were not responsible for making any changes. It was only through having a persistent PPG that provided relatively straightforward solutions that they addressed the issue after six months of discussion.

Practice nurses and management in the case of proposed changes to INR testing perceived first and foremost that the PPG should not be the place for this issue to be aired. It was considered to be outwith the scope of the PPG remit. They subsequently perceived they had no authority to change the current arrangements in place to ensure safe monitoring of patients receiving warfarin therapy. Their commitment to having a PPG that effectively supported the practice to make improvements in patient care and experience did however lead them to investigate the issue fully before they decided to not proceed with any changes.

In both of the other examples (access to doctor appointments and call response times) the practice perceived they had both the responsibility and capability for making improvements and in both cases swiftly made a decision to act. They did however, because of their beliefs about the

characteristics of their patient population remained doubtful that their efforts would result in improved patient experience scores.

This practice was one known for being relatively active in terms of gathering and using patient feedback. The following findings relate to Blair Practice who were known to do little in the way of gathering patient feedback.

### ***Blair Practice Context***

#### ***Is the practice adequately resourced to provide good patient experiences?***

This is a small practice with a practice manager who manages the administrative and business elements. The practice manager has limited autonomy and all agreements are made collectively between the partners and the practice manager. There is a general sense from the GPs that they aim to provide a good service to their patients while avoiding becoming overly involved in regional initiatives, which is consistent with how the non-medical staff describe them. They rarely for example attend regional GP development days and have a negative view of regional developments related to their contract, questioning the purpose of certain improvement targets.

GPs are rarely seen stopping for breaks and often work well past their official working hours. As mentioned in the previous chapter there is no structured time allocated to having GP partner meetings, and staff meetings are often cancelled. Priority is given to the safety and well-being of the patient population and a weekly multidisciplinary meeting to discuss at risk children, vulnerable adults and/or families and clinical or practice developments appears to never be cancelled and attended by all 3 GPs.

Many believe that the practice is just too busy to consider improvements or indeed to formally ask patients about their views of the service. Most believe that seeking patient feedback is a complex thing to do and needs to be adequately resourced rather than something they can pay lip service to. GPs regard themselves to be too busy to absorb this type of work.

*"I suppose if ... if your job was to organise feedback from patients and you didn't have to be a GP with clinical problems and management problems and other problems as well as have occasionally a personal life and if all you had to do was think about feedback yes I suppose you would want to ask patients as they left the consulting room what they thought of that particular consultation and maybe previous ones and in some way find out what was actually in their minds. But I haven't got time to organise that."* (Blair interview, GP17)

### ***Does the practice view patient experience as a key quality outcome***

Although some staff highlighted that it would be interesting or useful to get feedback the vast majority did not view patient feedback as a key quality outcome.

*"Oh it is [patient experience] probably quite low down on all the other things. ...always something else more important which is maybe not the best."* (Blair interview, staff 9)

*"I always felt pretty sceptical about that [doing any patient surveys], I mean we did it because we had to or I think we were paid for it I am not sure but I mean I never took much notice....that shows you how much I bothered."* (Blair Interview, GP17)

Two staff (a receptionist and GP) thought feedback should be important but shared the concerns of most staff about the practicalities of how to gather it.

As indicated previously the patient population was significantly deprived and staff perceived that this influenced the ways in which their patients engaged with the practice about their experiences of care. Most practice staff (all roles) believed that that their patients were not really interested in providing feedback or in the overall quality of their experience.

*"I don't think they are that bothered...about their feedback being sought."* (Blair interview, GP 17)

Patients were perceived to have more important things to deal with in their lives than providing formal feedback to the practice.

*".... [patients have] got lots of things to do and they just want in and out." (Blair interview, staff 6)*

Most were perceived to have lower expectations than more affluent groups.

*"I don't think the patients here are as demanding as what they are probably in other centres. It is quite deprived here and ...they don't expect much..." (Blair interview, staff 13)*

*"People here really don't care that much as long as they're getting a decent service where they're getting their prescriptions or getting to see us, I don't think they're particularly bothered about anything else really." (Blair interview, GP1)*

Deprivation was also seen by staff to affect patients' interest, willingness and ability to provide written feedback. They were perceived as being less likely than those from affluent areas to put their concerns or complaints in writing, preferring to raise their concerns verbally in real time with practice staff or GPs.

*"They soon tell you if you're not doing it right" (Blair interview staff 14)*

*"... although they are quite good at saying to you 'I am not happy with that', I don't think they like to make something official, they don't like to take it any further.." (Blair interview, staff 16)*

Most staff also perceived that patients probably felt less able to complain and this as well as the provision of a good service was the reason they had received no complaints in the previous two years and traditionally received very few.

*"we get very few complaints from this practice and you know I think that's because 1) our patient group and 2) I hope because we offer a good service but I mean it is probably a bit of both....They lack confidence..., they may not appreciate what it is reasonable to complain about.... So I think that's probably why we get fewer [complaints]." (Blair interview, GP17)*

*"...relatively low in complaints which from my point of view I think it is very good because I think we are doing very well"*(Blair interview, staff9)

Although most staff perceive the lack of complaints to be mainly reflective of a good service and/or a potential lack of patient confidence to speak up, a few wondered that only providing opportunities to feedback in writing potentially discouraged patients from raising issues in any formal way.

*"I think the more deprived population are much less likely to do it. I think they're far less empowered, they're less literate."*(Blair interview staff 15)

*"if they are not happy, they do ask "how do you complain?"... you say well put it in writing to the manager and if you say that ...a lot of the time they don't bother. Whereas if you gave them a complaints form they would find it easier to fill that out."*(Blair interview, staff 13)

Surveys were perceived to be particularly problematic with this patient group. Firstly most staff thought patients were likely to throw them in the bin and that any responses would be particularly biased by the demography of their practice population.

*"Well their literacy level is so different. Their ability to complete the questionnaire and their wish to complete a questionnaire, I think you're going to get results that skewed to the ones that either want to complain or the ones who are very happy...the ones in between are very unlikely to be bothered."*(Blair interview, GP 15)

*"No, I think that unless it was really, really, bad feedback ... they maybe wouldn't put it on the form at the desk... I think that maybe the majority of them wouldn't send it back."*(Blair interview, staff 14)

Observations and minutes of staff meetings indicated that patient feedback or experiences were rarely discussed. The meetings were instead focused on discussing work procedures, rules and general housekeeping.

It is evident therefore from the three data sources (documentary analysis, observations and interviews) used within the case study that patient feedback was not viewed as a key quality outcome. This practice spoke of the pride they had in providing a service to patients who were often refused care elsewhere and most believed that patients would tell them directly if they were unhappy. Efforts to elicit their feedback in any other way were viewed by most as far less important as supporting their patients with significant health and social problems. Although some staff thought it might be helpful to receive feedback, written feedback (complaints, surveys and suggestion boxes) were perceived to be particularly problematic with this patient group. As a result, this practice did not gather feedback in any formal way beyond the national survey, apart from their small suggestion box which was not used.

*Does the practice have access to timely patient feedback data?*

This practice rarely received formal patient feedback. Staff indicated that patients never used the suggestion box and if they did it was just to write a swear word.

There was confusion over which years patients had received the Better Together survey and on examining the national Better Together website there is no clear indication of the frequency with which this survey will be administered to patients. Although there was evidence of the practice receiving a written report on at least one occasion (2009/10 report) and the results being publically available online, all of the GPs, nurses and practice manager indicated in interviews (conducted February and March 2012) that they had received no further reports and were unsure if and when patients had been surveyed.<sup>5</sup>

*“We don’t get the results and we don’t get to see what they are.... Never had anything back and I have gone to them [the Better Together team] about it and no they have not got one*

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<sup>5</sup> Better Together survey was conducted in 2009/10 and again in 2011/12. In 2010/11 practices who had scored equal or higher than the national mean scores on access were awarded the same access points in 2010/11 as they received in 2009/10 and were not subject to being surveyed that year.

*for us....The year before... 2 years running we've not had Better Together actual results..."*(Blair interview, staff 9)

The confusion surrounding when the Better Together survey had been administered and a perceived lack of a 2010/11 and a 2011/2012 report had led the practice manager to query with the national team as to why they had not received a survey report for 2010/11. The response they received was largely felt by the GPs and practice manager as unacceptable.

*"...was told that because we got full points the first year I was just awarded the same points this last year and they didn't do the survey. They didn't ask me if we wanted to opt out or anything, just did it! That's terrible don't you think?"*(Blair observation: 26/07/12 staff 9)

The practice did receive its 2011/12 data in June and although the practice manager made a brief reference to it in a practice meeting there were no discussions of how easy it was to understand or its acceptability to staff within the meeting nor was it discussed with me during observations that took place after that meeting.

*Does the practice have access to data that are capable of detecting small changes in patient experience?*

Apart from the Better Together patient survey with its associated limitations detailed above for Davidson Practice, Blair Practice has no access to formal feedback data that are capable of detecting small changes in practice.

### **Blair Practice Mechanisms**

The 2011/12 Better Together survey was the only way the practice received formal feedback during the time I was undertaking fieldwork in Blair Practice and is therefore used as an example to examine how the practice responded.

Situation –the practice kept their 2009/10 Better Together report in an A4 folder with other QOF data. The 2011/12 Better Together data were received by the practice in June 2012.



### *Mechanism (Stage 1 reasoning)*

#### *Feedback is believed to be valid*

All of the nurses, the majority of GPs and the practice manager had a number of concerns about the validity of the Better Together survey. These included concerns about small sample sizes, poorly worded questions and biased responses and GPs believed these to be concerns shared by many other GPs across the country.

*"I just found it odd, some of the things that they looked at and I don't know that you can necessarily draw much conclusion from it. " (Blair interview, GP3)*

*"...everyone had issues with it[the survey], .... they had issues with the questions, the number of patients it was sent to." (Blair interview, staff 9)*

*"...but just whatever way they'd worded the question, we weren't happy with the wording ...I think there were leading questions... think there were some complaints from the BMA or something, LMC, that some of the questions were leading questions..."(Blair interview, GP1)*

One of the GPs however believed that overall, the Better Together survey was less biased than the surveys they previously used because patients received it in their home. Previously the practice had handed surveys out to patients directly prior to their GP consultations and this was believed by this GP to be far more biased.

*"I can occasionally remember the practice receptionist deliberately not giving it to the awkward patients because she knew we would get adverse feedback..." (Blair interview, GP1)*

This GP also thought that post consultation surveys had previously influenced their behaviour.

*"I do remember when patients brought them in and I deliberately tried to be more, you know nicer, friendly." (Blair interview, GP1)*

When the practice received their 2011/12 report it was discussed in a multidisciplinary meeting.

*“The minute notes that “the GP survey report had been received – everyone was happy with the results although they noted that the number who responded was low.” (Blair documentary analysis notes, Blair Tuesday meeting – minute 26/06/12)*

This item was taken in this meeting along with four other issues all relating to service change and service delivery and it appears that little attention was paid to it. Apart from the mention of the small number of respondents to the survey there was no discussion about the results.

### *Experiences are seen as needing to be improved*

There is no inclination from most of the staff in this practice that experiences generally need to be improved. The GPs, nurses and practice manager believed that the first Better Together data indicated that patients were relatively happy with the service and their ongoing lack of complaints confirmed that patients were generally happy. There was no written evidence that any staff had suggested a need for improvement after the 2009/10 or the 2010/11 data were shared at the practice meeting even though the practice had one item scoring statistically lower than the national mean.

A few staff thought patients' experiences could be improved however their ideas were generated from their preferences and expectations rather than in response to any specific feedback from patients.

### *Feedback is for improvement and not external judgement*

Views about the Better Together survey in this practice were somewhat different to Davidson practice. Staff did not talk about the Better Together survey as a mechanism to withhold money from practices. It was nonetheless perceived by those who were aware of it as unhelpful for improvement because it lacked details of what the practice needed to change.

*“...it is useless, our old surveys were much better, ... we had some statements from patients about specific things they liked or wanted to see changed” (Blair interview, staff 9)*

*Feedback data are presented in easily understood ways that meet GP preferences*

There were no views about the format of the Better Together report made in any interviews nor did anyone have any specific preferences for how data are presented. The written 2009/10 report was however written on by one of the GPs and the comment indicated that for this person at least the use of percentiles were not easy to understand.

*“Don’t understand centile charts” (Blair documentary analysis notes, QOF reports and patient survey scores)*

***Mechanism (Stage 1 - no action) – improvement activity was not stimulated***

This practice’s lack of focus on patient feedback as a key quality outcome combined with their concerns over how difficult it is to get reliable feedback from their practice population and significant workload had resulted in them not collecting feedback in any formal way from patients. For the same reasons and the fact that all but one of their Better Together survey scores was above the national mean this practice also paid little to no attention to the Better Together data. The Practice manager did try on one occasion to weave one of the results into a discussion the practice team were having about enhancing patient information about prescription medicines however the GPs and others did not appear to listen or take it into account.

***Summary of Blair Practice Findings***

***Context***

This practice perceived that it had little **resources to collect or consider feedback, did not view patients’ experiences as a key quality outcome**, and had reservations as to how feedback can be best sought from their patient group.

Compared to Davidson practice, it provided far fewer opportunities for patients to provide formal feedback. Their limited provision for patients to provide formal feedback had resulted in them only receiving formal feedback from the national patient survey and they therefore had **no access to timely feedback**. They had for example, received no formal complaints over the two years preceding fieldwork. Although a minority of staff thought that this may be because many patients would find it difficult to read and complete the complaint form most perceived it to be a reflection of a high standard of service and associated high levels of patient satisfaction. The latter explanation was indeed reflected in this practice's 2011/12 Better Together survey, where they scored equal or higher than the national mean on all items apart from one.

This practice was not **structured in ways that support improvements to be readily made**. There was no forum or process by which the overall performance of the practice or the quality of service could be discussed. Partners did not meet formally together to discuss quality or performance with the practice manager on a regular basis, preferring to meet weekly to discuss clinical and social patient issues and only met to discuss other aspects of the practice when there was something specific to discuss. There were administrative staff meetings however their focus was very rarely on the quality of service. A weekly meeting did take place with the multidisciplinary team however as indicated in the previous chapter this was heavily focused on clinical and social matters and discussing and agreeing care plans for at risk individuals and families.

This practice like the others only had access to the Better Together data and its ability to detect small changes is as yet unknown.

### ***Stage 1 Mechanism (reasoning and action)***

Concerns over the **validity** of Better Together survey scores were similar to those within Davidson practice. Sample sizes were perceived to be too small and GPs believed that there would be significant response bias with more literate and negative people responding. Additionally most staff also did not perceive most of the informal feedback they received from patients to be **valid**. Staff

perceived that most of the informal complaints they received at the desk were from patients being unreasonable or under the influence of drugs or alcohol and these rarely reflected a need for **patients experiences to be improved**. Their survey data with all but one item score above the national average, reflected their collective belief that patients experiences of their service were largely positive.

Unlike the staff in Davidson Practice, GPs and the practice manager perceived that the Better Together survey was a tool that had been designed for **improvement and not external judgement**. They did however perceive that the survey lacked the capacity to support the practice to specifically identify which aspects of their service needed to be improved, preferring the previous GPAQ surveys they used prior to the establishment of the Better Together survey programme. This combined with their concerns over validity led them to pay little to no attention to the reports they received. Lastly staff in this practice did not talk of their ability or lack of ability to **understand** the Better Together data and apart from the confusion about when they should expect survey reports they appeared to have not considered how the data were presented and how useful that was to them as a practice.

This practice was selected because of its lack of attention previously paid to gathering patient feedback. Findings from fieldwork confirmed that they provided few ways in which patient could provide formal feedback and paid little attention to their national survey data. Despite this however their national patient survey scores were in all but one item higher than the national average and demonstrated little room for improvement. Few saw the results from this survey as valid due to its perceived lack of representativeness and GPs and staff could not offer any solutions to overcoming this in the future. They had significant concerns over how best feedback from their patient group could be gathered, perceiving literacy barriers and 'chaotic lives' of some of their patients to limit participation in completing surveys, joining a patient participation group or taking part in patient experience interviews. Overall patient feedback was perceived as somewhat unnecessary by most as they collectively believed that most of their patients were more than happy to be honest about their

experiences and that they would quickly know if improvements in patients' experiences were needed.

### ***Sutherland Practice Context***

#### ***Is the practice adequately resourced to provide good patient experiences?***

Sutherland is a small rural practice which is very pro-active in working with the CHP or other agencies to pilot new ways of working. Staff meet formally every month with all the partners and any medical students on placement to discuss practice issues; staff issues and/or changes in legislation or the ways services are to be delivered or managed. All staff are encouraged to co-produce an agenda for this meeting and to contribute to discussions on how best the practice can be run or how problems can be resolved.

Although this practice was small they had a higher proportion of older people and far lower deprivation than the other two practices. Demands on their service appeared to be lower than that in Blair or Davidson practice. Patients were more frequently offered appointments on the same day when they called for an appointment than in either of the other two practices, despite all three having emergency appointment slots available every day. There were often unused appointments slots, staff talked of how surprised new patients were with that level of access to the service, GPs rarely missed their breaks and staff meetings appeared to very rarely be cancelled.

#### ***Does the practice view patient experience as a key quality outcome?***

All staff indicated in this practice that patient experience was a key quality outcome.

*"I hope it [patient experience] sits quite high [as a quality outcome] because that's what it is all about, we shouldn't lose ourselves in all these points and things..."*(Sutherland interview, GP 1)

*"I think yes, it is important for us all yes....I find it useful because we always think that we're doing a good job but it is nice to get the feedback to confirm that's what we're doing and not just you think you're doing a good job ..."*(Sutherland interview, staff 4)

*"So I think it certainly is important to them [GPs] to know how they're doing, but I mean even you know even right down to the receptionists and everything I think it is all really important."*(Sutherland interview, staff 6)

They did however do little to seek feedback in any formal way from patients and one GP stated that they had only done this previous to the national survey because they had to.

*"I think in the past the surveys were done because we had to do them."*(Sutherland interview GP 1)

Collecting patient feedback, using a survey in particular, was seen as time consuming. Support from their CHP to undertake surveys on their behalf prior to the Better Together survey was seen as not only helpful in that it saved the practice time but also provided a way in which patients could feel confident about the anonymity of their responses.

*"...and that's [not doing own our surveys] probably mostly because it is time-consuming and we had the backup from CHP ... and the patient could honestly either put it in a sealed envelope and we would collect them or send it directly to the CHP ... gave the patient the idea..., that it was independently done, whereas now we can't guarantee that, we don't have a way of doing that."*(Davidson interview, GP1)

Although all acknowledged that the practice did little beyond the national survey to collect feedback, some perceived that getting feedback from patients was more important now than ever before. They indicated that whilst this practice had always focused on providing excellent services to

patients and believed it still did so to a large extent, the introduction of the QOF had led to some changes in their priorities.

*"...I think things aren't as great as they have been in the past. I think on the whole, yes, most people would say, 'Yes, it is fine,' but I think recently things were not-, we're not informing patients effectively, efficiently as what we should be doing, we're not listening as effectively as we should be."* (Sutherland interview, staff 8)

*"...do feel of late they have kind of lost their way, so patient feedback perhaps they ought to do it more often....I'm surprised they didn't know before the survey that people were not happy if it is [the practice] reputation within the village."*(Sutherland interview, staff 7)

The practice's 2011/12 Better Together report somewhat reflected this perception, in that they scored the same or statistically better than the national mean on all but one indicator. However, patients' rating of overall care was statistically significantly lower (worse) than in 2009/2010.

Like Blair Practice, Sutherland received very few complaints. While in Blair Practice this was interpreted by the GPs and some of the staff as an indication of patient satisfaction, all of the GPs and most staff in this practice were cautious about viewing a lack of complaints, or a large number of thank you gifts or cards as reliable markers of patient satisfaction.

*"... but at the same time not getting any feedback [talking of lack of complaints and suggestions]you know it is like you just wonder you know we can't be that good, that we're doing everything right there must be something... so it is kind of not helpful in a way."*(Sutherland interview GP 6)

*"I think, for instance, presents to the practice.... People try to get ... they buy favours with that...so it is nice when people give you positive feedback but I don't really listen to it"*(Sutherland interview, GP3)



Most staff believed that a lack of complaints was more likely to reflect a reluctance by patients to complain direct to the practice.

*“Staff are talking about a feature in the local paper indicating that patients from a nearby practice had complained about the practice on facebook. (Staff 5) responded saying that she understood why people got angry and went to facebook sometimes as she knew that patients didn’t like telling the receptionists about what was wrong with them, let alone they were unhappy.”(Sutherland observation notes, 26/07/12)*

*“because a lot of people won’t... no I’m not complaining because what happens if I have to go to them again, well it is not like that but you know that’s their perception.”(Sutherland interview, staff7)*

Having a PPG was seen as a useful way to overcome some of these issues and the practice had sought support to establish one before being approached to take part in this study. The first meeting of the PPG was held at the end of my fieldwork.

This practice clearly perceived patient experience as a key quality outcome but had been less proactive than Davidson practice in establishing ways in which patients could provide that feedback.

#### *Does the practice have access to timely patient feedback data?*

Sutherland Practice, like Blair Practice, only received feedback from the Better Together survey report, some thank you cards and gifts and very few complaints. They do have a prominently placed suggestion box (although with no paper or pens freely available to make suggestions) but all staff indicated that this was never used by patients.

There were no concerns expressed about time between data collection and reporting of the Better Together results nor was there any concerns expressed about the time since patients had visited the practice and received the Better Together survey.

Does the practice have access to data that are capable of detecting small changes in patient experience?

Sutherland is similar to the other two, in that it only has access to Better Together survey results with its associated limitations. It therefore has no quantitative way of detecting small changes in patients' experiences

### **Sutherland Practice Mechanisms**

#### **Mechanism (Stage 1 reasoning)**

Example - How the practice responded to its 2011/12 Better Together report

#### **Feedback to believed to be valid**

The validity of Better Together survey went largely unquestioned in this practice. GPs and a receptionist indicated that this was perhaps because their survey scores tended to be positive and they would be more likely to criticise it if they scored poorly

*"So it (the Better Together survey) kind of gives you a little bit of reassurance but if it would be negative, you would kind of start thinking about the way the wording is....So it is not, well, like anything, it is not a hundred per cent but yes it is okay."*(Sutherland interview, GP3)

GPs tended to think that the Better Together survey was less biased than those previously used. They believed that previous surveys were only given to patients that had booked appointments with their preferred doctor, so were likely to provide positively biased responses. It was however not accepted without critique. Some of the questions in the Better Together survey were thought to potentially have multiple interpretations and one GP questioned if the sample sizes were sufficiently representative.

*"I think it generally should be quite reliable but you know with the assumption that you do take a large enough cohort of patients to average everything out."*(Sutherland interview,GP2)

When faced with their Better Together 2011/12 survey data which was largely positive the only item whose validity was questioned was the one where they scored statistically lower than the national mean. One GP and all of the reception staff did not believe the score reflected what they heard from patients in the practice but two practitioners thought the opposite, that this was how patients perceived their care experience and therefore should be taken at face value.

*"I don't know what that (lower score) means really but it was negative so I mean, yes, we were a bit concerned about that and I've been thinking what should I ... how should I interpret this?"*(Sutherland interview, GP3)

Receptionists also believed that survey scores were very dependent on who had been sent the survey rather than an accurate reflection of the quality of care. They believed it to be possible to get different results each time you administered a survey and therefore paid little attention to the results. Again though, positive scores tended to be taken at face value and not subject to the same critique of negative.

*"I find it useful because we always think that we're doing a good job but it is nice to get the feedback to confirm that's what we're doing..."*(Sutherland interview, staff 4)

Overall however, this practice questioned the validity of their Better Together data far less than the other two practices and additionally did not accept the feedback they received in person as a reliable alternative way of understanding patients' views of the quality of service.

### **Experiences are seen to need to be improved**

In general GPs perceived that the surveys they had used previously within the QOF, prior to the Better Together survey had been more helpful in identifying what needed to be improved.

*“The GPAQ ... you had more individual information and that was more specific and that was quite helpful because that’s where you could pick some things up because there was also a comment box, where people could make comments and that’s where it was clearer who it was and what it was about.” (Sutherland interview, GP1)*

Like Blair Practice, the 2011/12 Better Together report indicated that there was little room for improvement in patients’ experiences. They had the same or statistically higher (better) scores than the national mean for all but one item.

When faced with this overall positive report there was mixed responses. Nurses and reception staff were reported as having been delighted as their scores were better than previous and there was friendly rivalry evident in conversations in the practice.

*“we were fine, we got 100% , more than we can say for the doctors, they never got that on the Better Together. Patients like us you see and they both laughed.”(Sutherland observation notes 26/07/12)*

GPs however had been concerned about their one lower score and had discussed this with each other and practice staff. Some staff had noticed that it had affected GPs’ morale.

*“I don’t think he was happy with a few results...I think that was more of a shock than anything because I think he expected it to be better...I know it is a shame that this knocked them back a bit ...”(Sutherland interview, staff6)*

GPs told me that that they had at first had been a little disappointed by the score.

*“received it [Better Together report] in May but had been slightly disappointed with the results. I asked why - were they lower than he would have expected? [GP] said yes they were and was not sure why. [GP] said that because it was a small practice and they got to know most people he thought the scores would not have been so low... “just thought we provided*

*a better service through their eyes than what we have been rated”.*”(Sutherland observation notes, 16/08/12)

Even though they normally regarded face to face feedback as unreliable they perceived that the survey feedback did not necessarily reflect the more informal feedback they received routinely.

*“...I think there is a reasonable satisfaction of the service we provide. So in that sense we all feel that the feedback that we got from the national survey doesn’t strike with how we feel we get...we have cards or letters from patients ... that say “We’re sorry to have to leave here because of the service we’ve had” and often people that come from England, they’re surprised with the service that they get here and they openly say that.”*(Sutherland interview, GP1)

The GPs had shared the report with all the staff and asked them for their opinion of the reason for the one poor result. Most staff did not indicate they thought experiences needed to be improved. They either attributed the result to responder bias and/ or inferred there was little the GPs could do different:

*“Respondent - Well they did ask what had gone wrong [when they received the results]*

*Interviewer - Aha and did any of you have any suggestions about what could be done?*

*Respondent - Well we just said it depends, I said to them it depends who got the questionnaires sent to them because I mean every practice has got these patients out there that’ll, they’re never going to be happy no matter what you do I said and if you’ve got a few of them that’s filled it up, I said but none of the patients that think we’re absolutely wonderful filled it up then I said it all comes down to who’s actually fills it in. it could be totally different next year.”* (Sutherland interview, staff 4)

*“it is just down to your [their] personality isn’t it I suppose it is just down to that doctor and .. it is something that you can’t really change about that... I’m sure they do good, I’m sure they don’t deserve what they got but”*(Sutherland interview, staff6)

Two staff did however think the service in general could be improved and patients’ experiences of consultations could be better.

*“Right now I think things aren’t as great as they have been in the past. I think on the whole, yes, most people would say, ‘Yes, it is fine,’ but I think recently things we’re not-, we’re not informing patients effectively, efficiently as what we should be doing, we’re not listening as effectively as we should be. I hear them when I go home from work or go into the shops or whatever.”*(Sutherland interview, staff 8)

GPs had paid significant attention to their lower scored item and talked about trying to understand the reason behind the lower score. They said in the absence of any other information or comments from patients they had concluded that it might be because patients have such ready access to GP appointments and thus their expectations of GPs to be able to diagnose non-specific symptoms in the early stages of a condition/illness and treat effectively were far higher than larger practices.

*“ ... the difference between our practice and other practices is that we have very easy access .. the doctors see everything so it is not that we’ve got nurse practitioners that will filter out and we see things often very early on and so you don’t commit to a certain diagnosis at that stage often and it can come across as if we didn’t know what they were doing or what’s what. I think that’s the main thing that we can see as an issue because we have enough appointments, we have enough time and I think we spend enough time with the patients, that’s usually the feedback that we used to get”*(Sutherland interview, GP1)

They also perceived that they needed to listen to patients impressions of them but from the survey scores alone it was difficult to know what needed to change and further exploration of issues would be helpful.

*“so I mean, yes, we were a bit concerned about that [one low score] and I’ve been thinking what should I ... how should I interpret this? .. I don’t know, it is ... it would be nice for me to have somebody to go and explore that for me... why they did give that comment? What made them? ...But then you’re just people..”(Sutherland interview GP3)*

The practice was therefore divided in their belief about the need for change. Most of the staff appeared to consider the GPs as well regarded, and did not necessarily believe the score was reflective of their practice. A few staff thought the doctors could be better listeners in consultations and should try to engage with the local population to consider how they might improve care experiences. The GPs themselves were unsure if there was specifically anything they could change. All believed that a patient group might help them understand issues such as this more easily.

### **Feedback is for improvement and not external judgement**

No-one in this practice talked about being concerned about the Better Together survey or its previous link to QOF payments. Additionally no-one indicated that they were concerned about the data from this survey being used for judgment. GPs and one staff member in the practice did however discuss how more practice specific data would be more helpful than the generalised feedback Better Together survey provides.

*“... because obviously ... every practice has their own weaknesses and their strengths and.... maybe have been highlighted in the ‘Better Together’ surveys ...you could take out of that [a below mean score on Better Together survey] and kind of like look at that in a bit more detail so have a bit more have a questionnaire, a bit more focused on that....I think that would be more helpful.”(Sutherland interview, staff6)*

*"I don't think it [Better Together survey] gives us any clue if there is something that's not so good. It is hard then to say why is that? So it doesn't always give us an answer or give us a ... it just kind of picks, make you just be a bit more alert and then look at it and then maybe explore it further so I don't think it is the great answer to everything... it could be interpreted in so many different ways but at least they've answered it so, yes, we should maybe take a little notice of it and then think about it."*(Sutherland interview GP3)

*"... there are a few parameters where we underscore quite significantly but there's no way of finding out more information about it and so it is just very vague"* (Sutherland interview, GP1)

### **Feedback data are presented in an acceptable and easily understood ways that meet GP preferences**

GPs held similar views to their colleagues in Davidson Practice about the use of a national mean. They too believed that comparisons between them and similar types of practices would be more useful than a national mean.

*"... and it doesn't allow to compare between, because you compare yourself with all the other practices, so you can't compare with similar small practices or similar rural practices. So it is ... you're stuck [in knowing what needs to change]."* (Sutherland interview, GP1)

In addition to the format of the report this same GP indicated that the provision of an annual report would be far more helpful as this would allow them to understand trends and therefore what they should focus on. None of the GPs or staff commented on how understandable the Better Together survey report was.



*Mechanism (Stage 1 action) – improvement efforts focused on delivering care differently were not stimulated but efforts to better understand patients views of the service were made*

Following discussion and debate amongst the team and the GPs and a resultant lack of clarity or suggestions as to what specifically needed to change the GPs did not change anything specific to the way in which they consulted with patients.

*“so I shouldn’t get too worked up about all that, I do have to learn, I do have to listen, I do have to, I’m not perfect and I have to adapt and try better sometimes and that’s part of the parcel and you do your best and at the end of the day you’ve got to rest in that knowledge that you do your best.”* (Sutherland interview, GP3)

They did however continue with their plans and made arrangements to hold their first PPG as they saw this as a way of better understanding patients’ needs and views of the service.

## **Summary of Sutherland Practice Findings**

### **Context**

This practice was **well resourced to provide good patient experiences**. Most days there were appointment slots that went unused. They viewed **patient experiences as a key outcome of care** had very few reservations about how to best engage with their patients however, like Blair Practice had done little to seek formal feedback from patients.

Also, like Blair this practice rarely received any formal feedback apart from thank you cards and gifts and very few written complaints. Their suggestion box had never been used. They therefore **did not have access to timely feedback** as they were predominantly dependant on the Better Together survey reports produced every two years.

This practice did have **structures that supported improvements to be readily implemented**. They had a fortnightly all practice meeting and all staff were encouraged to contribute to discussions

about the quality of the service. All staff also indicated that their team was very open and any concerns they had about any aspect of the practice could be openly discussed and resolved without fear of blame.

### *Mechanism (Stage 1 reasoning and action)*

When the practice received their Better Together results the survey was shared with all staff and discussed at one of their all practice meetings. This practice team **did not question the validity** of the survey in any significant way and some GPs and staff believed this may be because they had scored so highly.

Practice staff were however more sceptical than GPs of the national survey. They perceived that scores could have been skewed by responder bias but as happened in Davidson Practice, only questioned the item where they scored lower than the national mean, leaving scores that reflected positively on their own practice unquestioned.

This practice did on the whole believe **that there was need for improvement**<sup>6</sup> in at least one particular aspect of their practice but were unsure on how improvements could be made. Although GPs had asked for staff feedback on what they think contributed to the score staff had not offered suggestions or their knowledge of what local people had said about the practice. This was despite a prevailing culture where staff reported it as easy to raise issues and believed their suggestions were listened to and relationships within the team appeared to be positive.

This practice perceived the Better Together survey to be designed **for improvement and not for external judgement** however due to its limitations in specificity of questions and the lack of comparisons with similar sized or located practices they felt it was limited in its ability to inform improvements.

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<sup>6</sup> The specific item has not been disclosed to maintain anonymity of the practice.

GPs in this practice **did not highlight any difficulties in understanding the Better Together survey data** however they, like Davidson Practice GPs would prefer to have their Better Together data in a format that allowed them to draw comparisons between similar located and sized practices.

In this practice no changes were made because a) all but one survey item was scored equal to or higher than the national average and b) the one survey item that was not provided not clarity on the specific issue that needed addressed. Some GPs therefore distanced themselves from it by either stating that some aspects of how they personally practiced was influenced by their personalities and therefore largely unchangeable while others settled on explaining the low score as an unintended consequence of providing easy access to doctor appointments and therefore again, was largely unchangeable. The GPs did however note that it was important to better understand patients' experiences and explore what might have led patients to score survey items in particular ways and set about establishing a patient participation group.

## Summary

Deciding to initiate improvement efforts in response to patient feedback in General practice is not straight forward. The CMO goes some way in explaining the contextual features of practice that facilitate a practice to be proactive in gathering and responding to patient feedback. The reality however is somewhat divergent from this where individual team's responses to patient feedback is influenced by their specific local context.

Findings from these three case studies indicate that the contexts of each practice differed in significant ways which affected how much effort each put into engaging with patients to gain their feedback, how they viewed the formal feedback they gained, predominantly through the national survey and in how they responded to feedback when they received it. A decision to attempt to make improvement efforts in response to feedback is critically dependent on key stakeholders perceiving that experiences need to be improved and someone taking the responsibility to implement such

improvements. This mechanism is however the least frequently occurring across the three practices. Now, this may be because there was little apparent scope for improvement in the national patient survey reports of Blair practice and Sutherland practices. However, even in Davidson practice who were very proactive in trying to make improvements in patients' experiences and where national patient survey scores demonstrated a need for improvement in several aspects of patient experience, decisions to try and make improvement were mostly prefaced with initial criticism of the validity of negative feedback regardless of its format (survey, suggestions, PPG comments or complaints). GPs in Sutherland were an exception to this rule however. They perceived that most formal feedback was valid and that informal feedback given at the desk or in consultations is not and thus, immediately engaged in self-critique when results from their Better Together survey were reported as being below the national average.

One key contextual feature not represented in the CMO that appears to influence the mechanisms in response to feedback is the practice's perceptions of their patient population and how likely they are to give feedback, practice staff perceptions of how they perceived the quality of care and the degree to which they perceive their patients are interested in their care experience. These perceptions act as a lens through which all patient feedback is perceived in all three practices.

In Blair practice patients were perceived to be unlikely to care much about how their service was delivered, to be largely satisfied with the service and likely to let the practice know if they were dissatisfied. This combined with overall positive survey scores and little time or inclination for GPs to address anything beyond their contractual requirements appeared to influence this practice to pay little or no attention to survey results and to take no action in response to it.

Sutherland Practice on the other hand, thought that patients cared greatly about how the service was provided, thought it entirely possible that patients experiences might need improved and that if dissatisfied would be unlikely to tell the practice staff directly. This appeared to heighten the attention this practice paid to their national survey results and even though their results were

overall positive, they discussed the results in detail at their practice meeting and decided to establish a PPG to try and understand how they could make an improvement on the one score where they scored lower than the national average.

Beliefs about patients were different again in Davidson Practice. Patients were perceived to be overly critical of services. Most staff also thought that patients did need a range of ways to be able to provide feedback, not because they perceived that patients would be unlikely to voice their concerns direct but more because they had experience of patients complaining to them and also complaining publicly through Facebook, the local press and their local MSP. These perceptions appeared to lead this team to always initially challenge the credibility of any formal feedback. Not perceiving formal feedback to be valid did not (as the CMO would infer) prevent the practice from coming to a decision to act however. Davidson Practice staff did for example always question the validity of the Better Together survey but they received regular feedback before receiving their formal survey results and had already judged that change was needed based on other feedback from suggestions and complaints, what patients were telling them, from their colleagues in interactions and from what they heard in the local community. Some of the survey results therefore, although initially questioned only served to formalise what was already known to them.

Coming to a decision to act also appeared to be strongly influenced by perceptions of responsibility and a culture where decisions were thought to be best made by consensus. In the example of the lack of privacy at the reception desk for example, apart from overall concerns about the validity of the Better Together survey results the reasoning of the practice representative at PPG meetings was consistent with Stage 1 in the CMO. Nonetheless, this practice representative also perceived initially that the problem lay with patients' behaviours at the desk and it was therefore not the responsibility of the practice team to address it. It therefore took some time to gain consensus on how the improvement could be addressed and significant negotiation and patience on the part of the PPG before agreement was reached. Similarly, in the INR testing example there was little consensus

among the patient members or between the practice representatives and the PPG membership as to the “actual” need for change and again it took time for consensus to be reached. A decision not to change in the INR example was influenced by another issue that is not detailed in the CMO – feasibility. In this example, policy and safety guidelines were interpreted by the practice team as preventing them from making any changes to the current practice based monitoring and once this was shared with the PPG a consensus to not change current monitoring arrangements was reached.

The analysis of findings from three case studies highlights that many of the features detailed in the CMO are important in stimulating GP practices to attempt to make improvements in patients’ experiences in response to formal feedback but at times practice teams will decide to try and make improvements even when their reasoning is inconsistent with that detailed in Stage 1 of the CMO. Other contextual features not reflected in the CMO were also found to be important, namely the overall focus the practice has on quality and what they believe about their patient population. Views about their patient population also appear to influence staff views about any patient feedback they receive.

Further reasoning, beyond that depicted in the CMO was seen to take place in some instances before the Davidson and Sutherland teams made decisions to act. It appeared critical that the practice teams could specifically determine what needed to improve and that they were able to identify a person who is willing to take on the responsibility of leading changes in practice.

Findings from this part of the study ultimately demonstrated that not only are there different kinds of reasoning operating in the three practices but that different reasoning can occur in response to feedback from the same feedback source in the same practice. Rather than negative feedback always stimulating improvement efforts, considerable contextually influenced beliefs and perceptions need to be overcome before this is possible.

The stimulation of improvement efforts is of course only part of the journey of improvement. To achieve improvements in future patients’ experiences, practices need to be able to successfully

implement and sustain changes. Improvement efforts were only stimulated in Davidson practice therefore the next chapter focuses on how this practice managed the improvements they committed to and compares what happened in practice with the proposed mechanisms 2 and 3 and assumptions 3-4 in the revised programme theory.

## **Chapter 6 Stage 2 Findings (b)Improvements in response to patient feedback – how they are implemented and the impact they have**

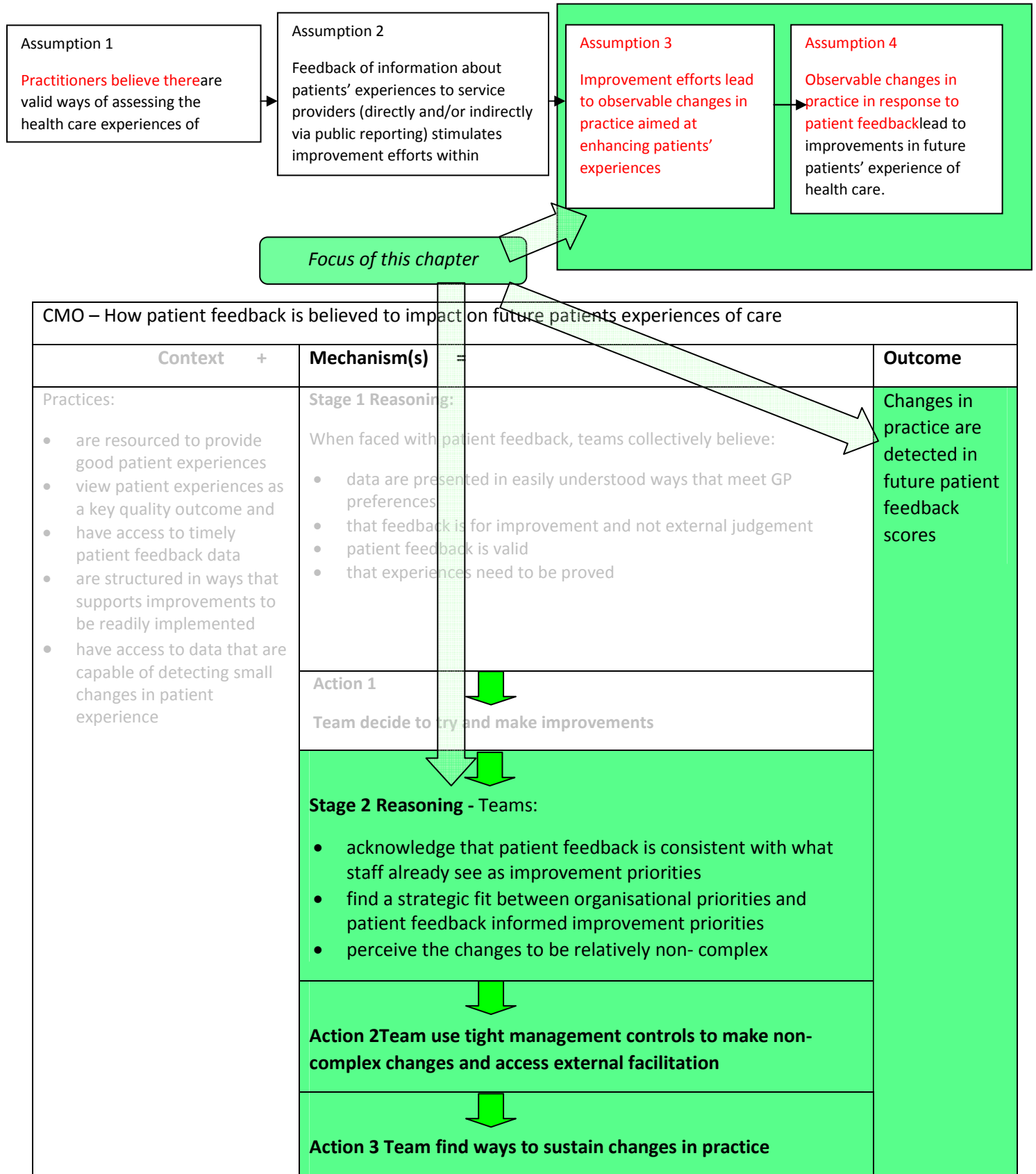
### **Introduction**

Davidson Practice was the only practice where improvements efforts directly aimed at enhancing patients' experiences were stimulated. Four examples from this practice, typifying main mechanisms observed in response to a range of patient feedback were introduced in the last chapter. In three of these examples (1, 2 and 4), decisions to make improvements were made and this chapter focuses on how they progressed with their improvement efforts.

It therefore shifts its focus to research aim three – to identify the strategies/approaches that appear to be useful in stimulating changes aimed at enhancing patients' experiences of GP services. It does so by examining how this practice took their improvement efforts forward and the impact these had and compares these with the assumptions 3-4 outlined in the refined programme theory and the reasoning and actions (mechanisms) 2 and 3 in the proposed CMO – See figure 11 overleaf).



Figure 11 Focus of chapter 6



Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

## **Assessment of the extent to which the reasoning and the mechanisms 2 and 3 are upheld in three improvements in Davidson Practice**

The CMO above highlights the assumed mechanisms (reasoning and action) that take place after a team have decided that they need to make changes to enhance patients' experiences. It is assumed that teams, after deciding to make changes, are effective in making attempts to improve when they view their patient feedback to be consistent with what they already see as improvement priorities; find a strategic fit between organisational priorities and patient feedback informed improvement priorities and perceive the changes to be relatively non- complex. Furthermore, it is also assumed that successful implementation depends on the use of tight management controls and may benefit from external facilitation.

It is worth reiterating at this point that the CMO was informed by the realist synthesis of intervention studies that examined primary care teams' responses to patient feedback. Authors of one such study highlighted that teams that made use of available external facilitation provided within an improvement collaborative and focused on non- complex issues in practice were more likely to attempt to make changes in response to feedback. It is not clear however in this study what level or type of external facilitation was available, or what "external" means or is the criteria by which a change would be described as "complex" or "non- complex" made explicit. These terms are therefore used to consider if facilitation of any type provided by anyone perceived to be external to the general practice was a factor and if the complexity of the change affects likelihood of it being successfully implemented and sustained where complexity is defined in broad terms. Complexity therefore can refer to the scope of a change – for example how many people or processes it affects, the number of elements involved in a change, how feasible a change is perceived to be and /or the amount of preparation and review a change may need.

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

Lastly the CMO assumes that for the outcome – “changes in practice are detected in future patient feedback scores” to be achieved then action 3 – “teams have to find ways to sustain changes in practice” must exist.

Details of the mechanisms (reasoning and action) that were observed in each example are now compared with these assumptions.

***Access to appointments with preferred GP (Example 1 from previous chapter)***

*Assumed reasoning: Patient feedback is consistent with what staff already see as improvement priorities*

The previous chapter highlights that perceptions of validity of patient feedback appear to be predominantly determined by the extent to which feedback matches the existing beliefs of staff working in the practice. This match is also detailed in the literature as key to determining how successful a team are in making improvements.

Staff in this practice knew that access to appointments with a patients’ preferred doctor was difficult through their previous patient survey results, their PPG discussions and their day to day feedback. They had gone as far as making a decision for two GPs to redesign the appointment system at their practice development meeting prior to receiving their latest national patient survey results. Despite this they did initially debate the validity of the patient survey results when they were received their report and debated how feasible it was to provide access to preferred doctors in large practices. There appeared to be an overall collective view amongst all staff that even though they would try and make improvements it would be unlikely that they would improve patients’ perceptions of access. It was seen as something of an intractable problem in terms of being an inevitable consequence of being a large practice that employs mainly part time GPs.

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

*“yesterday a man was complaining, he wants to see Dr x but he is not here today, he is off on a Thursday, he is fully booked on Friday so not free ‘til next week and the patient is not happy, we can offer another Dr but that’s not what he wants but you know that’s the way it is. We keep trying to change things but getting the balance between emergency and routines needs to be struck”*(Davidson observation notes,27/09/12)

While there was something of a match between patients’ views of access and staff views about the priorities for improvement this did not appear to be the only ‘reality’ that stimulated the GPs to try and address access. GPs were also at this time very concerned about their workload and their poor work life balance. They had been for some time feeling the strain of high activity and limited GP availability and this appeared to motivate them more than patients’ reports about access, to take on two additional salaried GPs (one to replace a GP due to retire and one additional to increase their overall GP resource).

*“...the doctors don’t take the decision to lose £10k wages a year lightly. They have all said they will pilot it for 11 months but if they feel it has no impact on them personally then they won’t continue but if it does improve things then they will probably give that person a partnership.”*(Davidson observation notes 27/09/12)

Patient feedback about a lack of appointments with their preferred doctor was therefore not an individual priority for improvement. Rather it was a perceived symptom of both being a large practice and having limited resources. Therefore the not insignificant solution to increase the number of GPs was an important practice development, aimed at ensuring GP’s well-being foremost and improving patient access would occur as a consequence.

*Assumed reasoning: Team finds a strategic fit between organisational priorities and patient feedback informed improvement priorities*

Much of the practice's organisational priorities are determined by the QOF. Practices previously were provided funding from QOF for patient access. Prior to data collection starting this funding had shifted to service improvement and efficiencies. This practice, like others in the region was therefore subject to a range of different improvement and efficiency targets. The practice indicated that this could be overwhelming at times and as well as trying to ensure adequate access to appointments they were at the same time being asked locally to decrease the number of referrals to hospital consultants, reduce admissions to A&E, increase surveillance and reporting on children not attending health appointments in addition to their existing QOF targets.

These additional targets were seen by the practice as having placed pressure on them to work in ways that may be helpful for overall patient outcomes but could have a negative impact on other aspects of patient experience. For instance they perceived that a reduction of referrals to secondary care specialists would require the development of GPs with special interests and although one GP may then see all or most patients with a particular condition, inevitably some of these patients may prefer to see another doctor. Simultaneously this 'special interest' doctor may be the preferred GP for other patients (without the special interest condition) and access to appointments with him/her for other ailments would be limited by the ring-fencing of some appointments for patients with the "special interest" condition. Patients using services structured in this way, although aimed at improving one aspect of the service (seeing a more expert practitioner to improve quality and consistency), could therefore lead to poor experience in terms of perceived poor general access to the doctor of the patient's choice.

This trade-off was however felt to be a risk worth taking by the practice as GPs believed that their roles were not only to consider what patients wanted but to also consider what they needed and to provide evidence based care. They therefore believed that they might have to educate patients at times about changes made rather than repeatedly change things to meet preferences.

*“Yes there’s some unhappiness about the triage system and we are aware of it and we are in the process of changing it slowly but we want to avoid doing the chopping and changing every three months to a new system because you know well it takes people time to get used to a system.”*(Davidson interview, GP 18)

***Assumed reasoning: Team perceive the changes to be relatively non-complex***

This change was not viewed by any in the practice team as ‘non-complex’. It included two GPs redesigning the appointment schedule and needed every partner to agree to take a pay drop in order to pay an additional salaried GP to enhance appointment availability. It also involved the introduction of new nurse led minor illness clinics to reduce the need to use GP appointments for this type of clinical need.

There was a collective belief amongst all staff and GPs that getting the balance right for appointment access was notoriously difficult. It was seen as difficult to organise and although new types of availability could be made such as nurse led minor illness clinics, GPs perceived that patients would take time to accept and use this to its full capacity.

Despite the evident complexity of the change and the personal impact on partners’ pay the practice did go on to try and make improvements.

*Assumed Action 2 Team use tight management controls to make non-complex changes and access external facilitation*

The programme theory assumes that once teams reason that they need to and will implement changes they are most successful when they use tight management controls and when they are supported through external facilitation. The following section considers how Davidson Practice managed the process of patient focused improvements.

*Tight management controls*

The changes did involve tight management controls. The practice manager for example supported the practice in the recruitment of a salaried GP, changing the appointments within the IT system and supported the senior nurse to introduce the nurse led minor illness clinics. They also ensured that receptionists were provided with information to effectively direct suitable patients to nurse appointments when they called looking for an emergency, same day appointment. Those responsible for the changes (the nurse and GPs) did however determine the rate of change and the ways in which it would be introduced. Support was only given to them when requested. The practice manager acted as a liaison between the clinicians and the office staff and ensured that they were well informed and engaged in making the change as successful as it could be. Engagement with staff was both within meetings and on a day to day basis. The partners also regularly reviewed the new systems at their routine practice meetings where they sought feedback from each other.

*Facilitation*

There was no external facilitation to support this relatively complex change which involved the recruitment of an extra salaried GP and a redistribution of the appointments within the appointment system.

The practice manager role was seen as one of a facilitator however by the GPs. She was regarded by all staff but particularly GPs as a manager who supported the practice to move forward with issues of importance, ensured they met regularly, had the information they needed to make decisions and helped them consider implications of various options.

*“..we understand we need to have somebody strong in the middle there that can amass the information, be a liaison between the patients that are coming with suggestions and ourselves and feed us the things that we need to know to deal with the complaints.”(Davidson interview, GP 12)*

This practice team use consensus to agree their key decisions and consensus for the employment of an additional GP was reached in 2-3 months. They indicated that they had a complex voting system detailed in their partnership agreement to use when consensus could not be reached, but resorting to voting was seen as a failure and had never been used since the formation of the partnership. Partners greatly valued their partnership relationships. They stated that although the practice manager could often effectively steer them to gain consensus early agreement was not always possible. They indicated that on such occasions they were prepared to either wait for full consensus and accept delays in the implementation of changes or prepared to forgo their initial preference if this was out of step with the opinion of others and compromise their relationship with the remaining partners.

*“We’ve never used the voting system at all it is all done by consensus and agreement. And I think we truly feel that if we had to vote, it would be a failure of the system and it is done by consensus and by discussion. And there’s a lot of opportunity for discussion, we spend a lot of time, I think, discussing things in partnership meetings and away days.”(Davidson interview, GP 12)*



This improvement effort could therefore not be described as non- complex and did demand significant input from management to introduce. Although they had no external facilitation the practice manager played a similar role to that of an external facilitator to the practice team.

*Assumed Action 3 –Team find ways to sustain changes in practice*

Discussions with the practice 10 months after field work was complete<sup>7</sup> highlighted that beyond that described above, there had been the need for tight management controls throughout the change process, specifically to manage unanticipated events and circumstances that threatened the success of the change. A GP had left to go on extended maternity leave and a sudden reduction in availability of locums meant that the normal contingency arrangements to cover maternity and annual leave could not be put into place. This had therefore temporarily limited their ability to maintain the level of medical staffing the new appointments had established.

*Assumed Outcome - Observable changes in practice in response to patient feedback lead to improvements in future patients' experience of health care.*

The extent to which these efforts had improved patients' perceptions of improvements in access to a preferred doctor cannot be determined until the patient survey is repeated and this had not been undertaken at the time of writing.

The impact of it however was felt to be affected by the existing contextual factors such as patient demand, preferences, contract related pressures, part-time status of GPs and by changes to the context that were not anticipated such as maternity leave and a lack of locum availability. Such changes in the context meant that the impact of an additional GP was not being necessarily felt by the GPs in terms of less workload or by the patients in terms of

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<sup>7</sup> I met with the practice manager 10 months after my last date of data collection to discuss with the practice manager their experience of and the progress they had made with the changes they had initiated or agreed during the time I had been visiting the practice.

better access to appointments. The practice manager believed that without the additional GP that they had appointed or establishment of the nurse led minor illness clinic however, things would have felt far worse for all concerned and now that they were back to full establishment their intended improvements in patients' experiences of access to appointments with their preferred doctor would be forthcoming.

She also indicated that even with the introduction of another salaried GP the part -time status of most other GPs was still a factor that would always limit the practice's ability to provide good continuity. This was nonetheless accepted as a limitation that the practice was willing to live with as it was believed that good GPs were kept in practice by allowing them to pursue their other academic and practice interests and as such, this ensured the highest standards of clinical care for patients.

***Getting through to the practice on the phone (Davidson example 2 from previous chapter)***

*Assumed reasoning: Patient feedback is consistent with what staff already see as improvement priorities*

The practice management were already aware through other data they had before they received their Better Together survey data that there were times in the day when phone calls were not being answered promptly. This was collectively viewed as a critical aspect of the service and this collective belief appeared to galvanise efforts around making improvements

*".. one of the main complain[t]s is the phones, folk trying to get through and I'll give her[change leader] her dues she is trying to resolve, trying to as best as we can and phones getting answered is a priority you know..."(Davidson interview, staff 25)*

*Assumed reasoning: Team finds a strategic fit between organisational priorities and patient feedback informed improvement priorities*

The practice was already aware there was little flexibility in administrative and reception roles and this led to inconsistencies in the quality of service that patients experienced. It was an aim of theirs to increase the flexibility, particularly when they had staff on sick and maternity leave and thus reduce the use of the need for recruitment of additional temporary staff during such periods. Additionally, the practice manager was considering retirement in the following two years and the practice was supporting a member of staff to qualify in practice management as part of their succession planning. This person was therefore looking for a project that would support their development of leadership and management skills.

*Assumed reasoning: Team perceive the changes to be relatively non-complex*

This change, although it started as a simple concept of sharing the responsibility of answering calls across the whole team could not be described as non- complex. There were a number of issues to consider including the impact of changes in practice on routine work, staff resistance to change, staff training needs on reception IT systems and appointment booking rules, breaking down of historical hierarchies within the administrative team where administrative staff dedicated to specific tasks perceived their work to be too specialised to be shared with reception staff, introduction of new phone lines; examinations of workloads and work flow and engagement of staff in determining how best the improvements could be achieved. All of this was also undertaken during a time of unprecedented and unpredicted administrative staff absence due to illness and maternity leave.

The change leader recognised the complexity of this change and often stayed behind at the end of an evening to work on planning the individual stages of the change and indicated to me in discussion that this preparation felt very helpful when they went into meetings with

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

staff, because they were well prepared, having given most scenarios and concerns some prior thought.

*Assumed action 2: Team use tight management controls to make non-complex changes and access external facilitation*

### Facilitation

Although this team did not directly seek external facilitation they were supported indirectly through the staff member leading the changes. This person was learning about change management as part of their practice management course and being supported and challenged to continually reflect on the change process both by the internal practice manager and the external course tutors.

### Tight management controls

Tight management controls were put in place to manage all the above aspects of this improvement initiative. The change leader initiated the improvements by explaining to staff the current status and how this differed from their desired level of service. She then engaged staff in agreeing on how best they could make improvements. Following this there were prompt decisions made on the way in which changes were to take place and when there was a lack of consensus in the team on the best way forward the leader informed staff of the proposed way forward and introduced it as a test with promises made to constantly review and refine it until they made it work.

Following this they set a start date for piloting new ways of working and created a rota to ensure everyone took a turn in supporting the answering of phones at peak times during the day. Regular meetings were held where the leader asked for feedback on what was going well and what issues needed to be addressed and constantly gave a commitment to examine the issues that were raised. She also repeatedly reminded people of the reason for the

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

change and staff indicated in interviews that while they would have preferred to not have had to change their routines and roles they understood and agreed that prompt answering of calls was of significant importance and thus something they had to work to address.

*“it is possibly about one of the most important things, the phones have to get answered first because you don’t know what’s on the other end.”*(Davidson interview, staff 29)

During the time when these changes were implemented additional staff went off on long-term sick with unexpected injuries and illnesses. Management of this situation led to a galvanising of efforts of remaining staff to make the improvements rather than a further reduction in service quality. The leaders immediately acknowledged with staff how difficult a time it was for everyone and the pressure it was placing on all staff. Simultaneously, staff readily witnessed that their colleagues, and in many cases friends, were under extreme pressure and patients were being delayed in getting through on the phones and at the desk. This appeared to motivate all team members to push their initial concerns aside and engage with the proposed changes.

Momentum also appeared to be maintained due to the teams’ overall commitment to this aspect of quality and two other key behaviours of the leaders (change leader and practice manager). Both role-modelled the behaviours they were seeking from staff and helped answer phones when needed and both made a point of thanking staff for their efforts and giving them feedback on how things were going and at the same time, showing a genuine interest not only in the change but in individual staff’s well-being.

A constant presence of management and leaders where staff were engaging with the work of the practice led to daily reviews of progress, identification of unintended consequences and opportunities where leaders reinforced and refined new ways of working.

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

*“[name] said to [change leader] that she would go and relieve staff from reception and sit through there while they took their breaks.*

*[Change leader] - are you sure?*

*[Staff name], yea that’s fine*

*[Staff name], I can help too , I’m trying to get on with some of the scanning*

*[Change leader] Well you continue with that because I know it is important to answer the phones but scanning is important too.*

*There was some discussion about the need for more people to be able to deal with electronic patient results. “I think [name] does hardly any scanning and concentrates on the phones.” This resulted in the change manager thanking the staff member for raising it as a good suggestions and stating –“yeah I will need to see about getting some [other staff] trained up.”” (Davidson observation notes, 30/12/11)*

### ***Assumed action 3 –Team find ways to sustain changes in practice***

This approach appeared to be critical in supporting this team to effectively implement and sustain their agreed changes. Having structured times when the majority of the team could meet and reflect on progress in an environment where staff felt listened to by their manager and felt their contributions were valued was also seen as helpful by staff along with repeated reinforcement of shared values and standards.

*“[practice manager]’s a good manager as well so I think if you’ve got a good manager and a good team.*

***So what makes her a good manager?***

*I think she's just good at communicating, she'll listen to you, any worries or anything like that, she'll take that on board but she can be quite firm as well."* (Davidson interview, staff 13)

***Assumed Outcome - Observable changes in practice in response to patient feedback lead to improvements in future patients' experience of health care***

The practice had after 10 months integrated this into their normal working arrangements and reported that it was working well the majority of the time. The practice manager was aware however that at peak holiday times there were still some points during the day where delays were being incurred and were looking to employ additional staff for impending maternity leave in order that this was not further exacerbated. They saw this as an essential strategy in keeping staff on board with their commitment to ensure timely response to phone calls. The manager of the practice had also been monitoring the length of time it took to answer calls and although could provide no figures stated that calls were increasingly being answered more quickly than before.

It is impossible to ascertain the impact the changes made directly on patient experience as the national survey had not been repeated by the end of case study field work. The practice did report however that since they had implemented the change they had received no verbal complaints from patients about difficulties getting through on the phone and that PPG members had indicated that they had noticed improvements in the length of time in getting through to the practice. This was a significant improvement as many of the staff had reported in interviews that they had received verbal complaints and comments from patients and the PPG about lengthy delays in getting through on the phones.

Discussions with staff at this time also indicated that the new ways of working had become part of their routine and was working well. They stated that they had repeatedly discussed the change as it was being implemented and had removed a couple of people from

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

answering the calls in order to avoid unintended adverse consequences (the excused individuals' work required high levels of concentration, and interruptions to answer the phone was perceived to potentially affect the quality and safety of the work they did).

***Privacy at the desk (Davidson example 4 from previous chapter)***

*Assumed reasoning: Patient feedback is consistent with what staff already see as improvement priorities*

This issue was not seen as an improvement priority by the practice representative at the PPG meetings and was disputed by a minority of patient members of the PPG who perceived that little sensitive information discussed at the desk. The findings presented in the last chapter demonstrated that after six months of persuasion from the PPG and a meeting where some PPG members expressed their frustration at the length of time it was taking to address this issue the practice eventually implemented the improvements even though this issue remained of little priority.

It appears that although this issue was never perceived to be a priority by the practice their desire to maintain a trusting relationship with the PPG where they are seen to be responsive to their suggestions was influential in ensuring the changes were put in place.

*Assumed reasoning: Team finds a strategic fit between organisational priorities and patient feedback informed improvement priorities*

Although the practice had received national patient survey scores that reflected dissatisfaction with privacy at the desk this issue never became a strategic priority in the practice.



*Assumed reasoning: Team perceive the changes to be relatively non-complex*

The changes needed to enhance privacy were relatively straightforward. They consisted of placing a stand with a poster asking patients to stand back and afford others privacy, moving a poster on the reception desk telling patients that they could ask to speak to a receptionist in private if they so wished to a more prominent position, and moving reception staff positions at the desk further apart so that two patients could simultaneously speak to receptionists and the ability to overhear conversations would be reduced. The practice team did not perceive this to be complex but they did resist making the changes for some time because they perceived the problem being addressed to be unimportant.

*Assumed action 2 Team use tight management controls to make non-complex changes and access external facilitation*

Facilitation

The practice did not access external facilitation to implement these changes. The PPG acted like an external facilitator however, reminding the practice of why it was important, making suggestions on how easily it could be addressed and constantly challenging them as to why the changes had not been made.

Tight management controls

This straight forward change was one where there were only physical changes to be implemented and no requirement for changes in staff behaviours or processes. It was therefore not something that needed any tight management controls to ensure it was embedded.

Assumed action 3 - Team find ways to sustain changes in practice

Four months after the changes had been made they were still in place and the practice manager indicated that most patients appeared to follow the guidance given and allow others privacy.

*Assumed Outcome - Observable changes in practice in response to patient feedback lead to improvements in future patients' experience of health care*

Again, because the Better Together survey has not been undertaken since the case study, the impact of the changes put in place on patients' experiences cannot be quantified. The practice manager did however indicate that within the four months after placing the signs in the practice they had received no comments complaining about the lack of privacy in their suggestion book. This was a stark contrast to what they had been experiencing before where they were receiving weekly comments in their suggestion book about the lack of privacy. One member of staff also indicated that since the signage had been changed a few patients had asked her if they could talk in private in the room provided and that they could not recall this ever happening before the changes had been put in place.

## **Summary**

This practice implemented three changes in response to patient feedback and in no instances were all the mechanisms (reasoning and actions) proposed in the CMO upheld. The two significant improvements – enhancing access to appointments and response times to phone calls that were readily taken forward by the practice without any degree of persistence needed from the PPG were consistent with the practice improvement priorities and their strategic priorities. This fit appeared to influence the speed with which actions were taken and the efforts and sacrifices made to ensure change was successfully implemented. The other example (privacy at the desk) was never perceived to be a priority

and as such, took persistent pressure over several months from the PPG before any changes were implemented.

Only the privacy at the desk could be described as a 'non-complex' change in that it only involved the creating and repositioning of posters and computers at the reception desk and did not require changes to financial arrangements or the recruitment of staff as with the improvements aimed at enhancing access to GP appointments. Nor did it require changes to staff roles, duty rotas or training as in the improvements aimed at enhancing the patients' experiences of getting through to the practice by phone. So, contrary to the findings in other studies, this practice appeared less likely to implement a relatively straightforward change that required little effort and resource than the more complex changes that required significant resources and effort to implement. Indeed complexity is perhaps not the most appropriate term to differentiate between these different improvement efforts. 'Significant' might be a better term' in that it alludes to the extent of the change, and therefore implies the effort that is required to implement.

The question still remains however as to why the practice more readily implemented the more significant changes than this less significant one. It cannot be explained by the influence of financial incentives as QOF payments for access to GP appointments were removed prior to the practice receiving these 2011/12 Better Together survey results and practices have never been paid for their patient survey scores relating to getting through on the phone. One explanation given by the practice management was that they were involved in making the more significant changes during a time where there were significant medical and administrative staffing shortages and this less significant change had just 'slipped'. Data from observations of the PPG meetings did however highlight another influencing factor.

The practice representative had been reticent from the outset to change anything at the reception desk because of the belief of the practice representative that the responsibility for

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

affording patients' privacy lay with the behaviours of patients themselves and not the practice. The other two changes were viewed differently with all staff perceiving that the practice had a responsibility around ensuring adequate access to appointments and timely answering of phones. While GPs initially debated the patient survey scores they indicated in meetings and interviews that patients spoke about how difficult it was to get an appointments and they collectively believed they needed to address it. So it seems that perceived responsibility for enhancing patient experience was significant in influencing the speed with which the practice implemented changes.

Another important consideration is the role of the practice representative on the PPG. They act as a filter and at times are perceived by the PPG to be a barrier between the PPG and GPs. The PPG have no direct access to GPs or nurses and have to raise and at times debate issues with the practice representative before issues are taken to the GPs. The privacy at the desk issue is one example that demonstrates how the beliefs held by one member of the practice about whose responsibility it is to address privacy at the desk issues strongly influences the speed with which the practice agree to address the issue. A number of the PPG members highlighted that this dynamic had been problematic and frustrating at times and many of them voiced a preference to have a GP attend meetings.

*"it would be good if one of the practice, one of the doctors, came and explained because sometimes, something [practice representative] says maybe leaves you frustrated, it is not a complete answer how [they] have projected it."*(Davidson interview, PPG member 20)

Both of the more complex changes required tight management to not only manage the planned change but to address the unanticipated consequences of the changes and the unanticipated changes in context. For example, unplanned reduction in staff availability

(administrative, reception, GPs and locums) significantly reduced the impact changes had on the outcomes predicted from each change effort.

In addition to tight management controls, good relationships between team members and the existence of a structure that supports ongoing open and honest critical review of progress appeared to significantly support this practice to make the improvements.

Leadership that is committed to both the people who work in the practice and the standard of service the practice provided was also perceived by staff and GPs alike to have been critical to their perceived overall culture of learning and improvement.

While this team initiated and embedded changes in practice in response to patient feedback without the assistance of an external facilitator a critical factor in each of the changes was the appointment of one individual to facilitate the changes needed. Their role was to consider and propose options, negotiate with staff and then monitor and manage the process of change. The structures in the practice also appeared to be crucial. Time was built in to schedules for staff to meet and discuss the overall performance of the practice and agree on specific improvements. Having scheduled meetings appeared to ensure that progress was being made. Additionally, the PPG meetings meant that as well as having structures that ensured the practice was constantly reviewing its own performance the PPG was a constant reminder to the practice of the issues that were of most importance to patients and worked in a supportive way by offering suggestions, working with the practice to gain other patients' views and to develop information for patients so that they were informed of how to get the best from their practice. The position of the practice manager in this practice also appeared to be significant. This person was highly regarded by all staff, thought to be very supportive to all staff, firm but fair in their management style and most of all very capable in managing all aspects of the service. All partners regarded this role as critical in progressing the practice and maintaining healthy partner relationships.

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

*“...it [the practice] has a good system of communication within the practice, with practice meeting and discussions. I think that’s really important. I think our relationship with the practice manager’s really key to that.... we do rely on her to do things, when we have ideas we take them to [practice manager] and we say “Right [practice manager], we need to look at this in more detail” and then [they] will set it up and help us look at it and the way we look at it depends on what [practice manager] comes up with I think often..., [they’re] a facilitator, [they’re] a catalyst and [they’re] also a cog in the decision-making process as well..”(Davidson interview, GP12)*

Tracking of the changes over time in Davidson Practice has highlighted that although change efforts were put in place they a) took significant effort that required strong, dedicated management and leadership; b) needed to be refined along the way and therefore took some time to embed and c) were temporarily negatively affected by unanticipated changes in the context in which they are being placed. As a result, such changes took some time to realise the benefits they were designed to deliver.

In addition, a lack of quantitative real time or near real time data made it difficult for this practice to identify the impact of their efforts on future patients’ experiences. They instead relied on process data (time to answer calls, number of available appointments and number of comments from patient relating to specific issues (access, privacy, call waits) to understand the impact of their improvement efforts.

This chapter has followed the process of change in Davidson practice and found that the assumptions in the proposed CMO were not always fulfilled for change to be successfully implemented.

A fit between the priorities of the practice and the changes implied as necessary by patient feedback did appear to be significant but so too did the degree to which the practice

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

believed it was responsible for aspects of patient experience. How complex, or more accurately, how significant a change was, was not found to be influential instead, once the practice had viewed the change as necessary and important it set about implementing it. Tight management of change did occur in this practice. There were three key features to this: regular management meetings to discuss overall practice performance and priorities; appointment of an individual to lead each of the changes and the support and guidance from the practice manager.

While the practice did not access any external facilitation individuals (staff and PPG members) acted as internal facilitators. The role of the practice manager appeared to be important in supporting those in charge of changes with developing consensus at practice meetings around suggested proposals, providing necessary practice data, requesting and making time to consider progress on changes and providing suggestions and mentorship to those that needed.

This practice was acknowledged internally by all staff as having strong leadership and this appeared to support them to sustain changes in practice. Changes in context outwith the practice control posed a number of challenges and it was these issues rather than the sustainability of the changes that limited the impact improvement efforts had on future patients' experiences.

Lastly, the length of time between national patient surveys limited this practice to understand the impact of their efforts and therefore they resorted to using proxy measures of patients' experiences such as comments and concerns raised by patients and the number of available GP appointments to understand the impact of their efforts.

This study has highlighted that practices respond to patient feedback in ways that are not always consistent with that assumed in health care policy and that the association between improvement efforts and improvements in patients' experiences is critically dependant on a

Chapter 6 Stage 2: Findings (b) Improvement in response to patient feedback- how they are implemented and the impact they have

number of factors that frequently go unrecognised in health policy or guidelines. The following chapter discussing the findings from patient interviews before the overall findings and their implications for policy, practice and research are considered.



## **Chapter 7 Patients' experiences of the service and their preferences for providing feedback**

### **Introduction**

Until now the practices have been described and examined through a professional lens. Patient interviews were included in this study to explore their experiences of the practice, their preferences for how their feedback should be sought and used, their likelihood of providing feedback to their General practice, where possible their experiences of providing feedback.

It was never expected that this data would directly inform understanding of how feedback was *used* in each practice, so it stands somewhat separate to the main research questions and is presented in a short chapter. Instead, these interviews were designed to provide a different perspective through which the context of each practice could be understood and identify, where possible, patients' experiences of providing feedback. Apart from PPG members in Davidson Practice, no patient participants had experience of providing formal feedback to general practice (perhaps reflecting that in the other two practices, there were limited mechanisms to do so beyond making a complaint). Interviews with remaining participants (non PPG members) therefore focused on patients' expectations of how their practice should gather their feedback about their experiences of the practice to explore how patients conceptualise giving feedback to their practice and to explore the ways that patients like to provide feedback.

This chapter is presented differently to the other findings chapters. Previous chapters were focused on considering in detail the CMOs in operation in each practice and therefore findings were presented case by case. The principal aim of this chapter is to present patients' perceptions and views of patient feedback. In addition and in a more limited way, similarities and differences between patients and staff in their perception of the practice will be explored. Findings are therefore presented topic by topic but in a way that each practice can still be easily identified. The limitations of this part of the study have been discussed in the Methods Chapter 3 (page 72). It

should also be stated here however that when terms such as 'all', 'most', 'some' or 'few' or 'minority' are used in this chapter they refer only to proportions of the participants who took part in interviews and because of the small numbers included, these perceptions and views cannot be generalised to the wider patient populations in these practices or beyond.

It should also be noted at this point, before reading this chapter that, similar to staff interviews, every patient who was interviewed in all three cases, referred to feedback about negative experiences when they were asked to consider how likely they would be to give feedback or their preferences for the ways in which they could give their feedback.

### **Awareness of formal feedback mechanisms**

Patients in all three practices were largely unaware of the ways in which they could provide feedback to the practice (see table 13 below).

**Table 13 Patient awareness of feedback mechanisms available**

	<b>Davidson</b>		<b>Blair</b>		<b>Sutherland</b>	
<b>Formal Feedback mechanisms</b>	<b>Provided</b>	<b>Patient awareness (non PPG)</b>	<b>Provided</b>	<b>Patient awareness</b>	<b>Provided</b>	<b>Patient awareness</b>
<b>Suggestion book/box</b>	Yes	No	Yes	Only 1 patient	Yes	No
<b>Website</b>	Yes	No	No		No	
<b>Waiting room campaign inviting suggestions</b>	Yes	No	No		No	
<b>Patient participation group</b>	Yes	Only 1 patient	No		( Yes ) - planned	( Yes ) Some patients aware of plans
<b>Complaints</b>	Yes	Yes	Yes	Yes	Yes	No
<b>National Better Together Survey</b>	Yes	No	Yes	No	Yes	No

### **Davidson Practice**

Davidson Practice provide a wide range of ways for patients to provide feedback beyond the Better Together survey however patients who were not members of the PPG were unaware of the Better Together survey and were largely unaware of other ways for providing feedback available to them.

***“In what ways do they [the practice] look for feedback about patients’ experiences?”***

*No, no I’ve no idea about that, no.*

***So they have a suggestion book at the front desk is that something that you’ve ever noticed while you’re here?***

*No I’ve never noticed it, no.”* (Davidson interview, patient 2)

All patients who were not members of the PPG perceived that their only option would be to complain to the manager or the ‘girls at the desk’. One patient was aware that there was a PPG but unsure of what its purpose was.

### **Blair Practice**

Blair Practice had a very small, cardboard suggestion box and no signage that prompted patients to use it. There were also no notifications up in the practice explaining to patients how they might raise a concern or complain.

Only one patient was aware of the suggestion box and all were unsure as to how they might provide feedback to the service. The one person that thought there was a suggestion box confused it with the repeat prescription drop off box that it was located next to. They thought patients could place suggestions in the box and staff separated comments from scripts when they opened the box. This patient thought however that if the practice wanted to get feedback using suggestions then they would need to place the box in a more prominent position and actively encourage people to leave comments.

*“I think it is in a bad place for a start, right? It is not in the main bit while you’re booking in, that’s where it should be. Even though it is a slot in the table and it is got a box saying “Suggestions” in here and you go and if they [receptionists] said “I’ve got the form here, would you like to go? ....because you’ve got to coach people to do things, they don’t. they’ll no dae it?” (Blair interview, patient 3)*

### **Sutherland Practice**

Sutherland Practice, like Blair Practice only had a suggestion box and a complaints system beyond the Better Together survey. Its suggestion box was however a large red metal box placed in a prominent position in the waiting area with a clear sign stating “suggestions”. They also had prominently placed posters on their patient notice board informing patients on how they could raise concerns or feedback any dissatisfaction they might have. Despite this, patients here were also mostly unaware of how they might give feedback. Only one had noticed the suggestion box. None were aware of the Better Together survey and all were unaware as to how they might complain.

### **Quality of experience**

Table 14 overleaf compares patients’ evaluations of service quality, and their likelihood and preferences for providing feedback with staff perceptions in each practice.

**Table14 How patients' experiences (of general practice care) and preferences (for providing feedback) compare with views and beliefs of general practice staff**

	Davidson		Blair		Sutherland	
	Practice	Patient	Practice	Patient	Practice	Patient
<b>Perceived quality of service</b>	Good quality of service, access could be better. Practice does its best.	Access is extremely difficult; continuity is perceived to be poor and to lead to delays in diagnosis/ treatment. Not all doctors listen effectively.	Good service, easy access to GP appointments, provides equality of care that's appreciated by patients.	Very happy with the service, ease of access to emergency appointments and preferred doctor. Particularly content that all patients are treated equally.	Good service but thinks it can always improve.	Very good service, no complaints. One suggestion that house bound patients could benefit from routine home review visits.
<b>Likelihood to provide feedback</b>	Patients are very vocal and happy to complain. They have unrealistically high expectations of service	Most patients unsure how to raise concerns. All reluctant to provide negative feedback to practice direct.  Tolerate poor service as perceive they have no option to register elsewhere.	Expectations from patients are low. Not interested in quality of service or providing formal feedback. More likely to verbally raise concerns at desk but this is rare – most are grateful for service	Most stated they would be glad to be asked for their feedback. Would happily provide feedback. Most would be reluctant to give negative feedback direct to individual practitioners.	Patients would be unlikely to complain directly to practice. Expectations of patients are influenced by previous levels of service. Minority of patients have unrealistically high expectations.	Opinions divided, One preferred to discuss dissatisfaction face to face with GPs. Others prefer more anonymous mechanisms. One person was unaware of their options.
	What practice think patients prefer	What patients prefer	What practice think patients prefer	What patients prefer	What practice think patients prefer	What patients prefer
<b>Preferences for providing feedback: Format</b>	Will complain and provide suggestions readily.	Mixed views. Just over half willing to complete short surveys. Overall preference for providing qualitative feedback (being asked few questions at desk)	Patients will complain if dissatisfied.	Varied preferences some preferred surveys, some preferred qualitative feedback.	Complaints and suggestions	Varied – discuss with doctor, surveys, doctor rating sites and PPG.
<b>Preferences for providing feedback: Process</b>	Verbal/written complaints at desk or to doctors. Write in suggestion book. Discuss in community	Feedback kept anonymous. Reluctant to provide negative feedback direct to practice. Mixed views about using doctor rating websites.	At desk or to staff direct in consultations	Varied preferences – Minority happy to complain face to face with GPs. Others very reluctant to do so and prefer anonymity	Discussing with others in community, avoiding direct discussion with practice. Minority will talk direct with doctor	Direct to doctor or surveys

## **Davidson Practice**

The staff in Davidson Practice believed that they provided a high quality service and although they were aware that there were some issues with access they believed they tried their best to ensure positive patient experiences.

Few patients however evaluated the quality of service to be high. Of the 11 patients interviewed; only 3 patients, all of whom were PPG members, perceived that the practice provided a high quality service. When asked about quality patients appeared to focus on access to appointments. Seven indicated that they (and others they knew of) found it difficult to get an appointment with a GP and 3 were particularly concerned over the lack of ability to get an appointment with specific doctors and a subsequent lack of continuity of care.

*“....difficult to get appointments, selected doctors is virtually impossible to get an appointment unless it is an emergency and you just happen to catch them, but if you go for[one doctor in particular], there’s one or two, three, four weeks ahead they’re booked.”(Davidson interview, patient 1)*

*“I get a different doctor every time. One tells me it is not [medical condition], it is [another condition]. The next one tells me it is a mixture of both. ... every doctor tells you something different, so to see the same one again and again would be a lot more helpful and I think they would know-, they would get to know you personally and your problem. You just kind of feel that you’re passed from pillar to post.” (Davidson interview, patient5)*

A minority of patients perceived this lack of access to appointments with a preferred doctor as an inevitable part of modern general practice however others found it highly unacceptable.

*“I was very disturbed by a letter, a newsletter which said that because none of the partners had a fulltime commitment to the practice if you wanted to see a particular doctor you would have to be prepared to wait and I thought well why does nobody have a fulltime*

*commitment? .... I kind of thought of my own profession if a letter went out from the school saying because none of our staff are fulltime your child would be having a different, whichever teacher is available from the pool of staff, students and probationers, there would be uproar.” (Davidson interview, patient 4)*

### **Blair Practice**

Blair Practice staff believed that patients received a high quality service and that the practice worked hard to be flexible and provide a large proportion of same day appointments to meet their patients' needs and preferences. They also perceived that they provided a service which was highly valued by patients who were often refused care elsewhere because of their social circumstances or lifestyle choices. Patients' views of the service mirrored the staff perceptions. The practice was described by all 4 patients as providing high quality services and all particularly liked it because of how easy it was to get a doctor's appointment.

*“Oh, well, I tell people that I've got a great doctor....I've never, ever had a problem. I've never, ever thought oh, that's wrong, they could have did that better than that.... you'll hear some of them [other pensioners] saying, oh, I couldn't get an appointment at the doctor. I say, well, you should come across to [practice], come across to [practice]” (Blair interview, patient 4)*

All four patients also shared their perceptions that the practice cared for everybody, regardless of their social or health background and while this sometimes led to a minority of people 'misbehaving' in the practice waiting area, overall they perceived this equality of service to be an attractive feature of the practice.



## **Sutherland Practice**

Sutherland Practice staff perceived that they provided a high quality service but had an overarching philosophy that improvements were always possible. They also perceived that newly registered patients were often very surprised to the ease of access to GP appointments in particular. Patients in this practice indicated that they indeed felt very well cared for by this practice and particularly impressed with the availability of GP appointments.

*“I used to live in [another region].... so it [is] that I use for a comparison, yes and because it was a big practice down there and they had so many doctors and you never saw the same one twice, three weeks for an appointment, that kind of thing. Whereas, first time I went down here I can’t remember who it was and someone said, ‘Oh I’m sorry, I can’t give you an appointment this morning, but oh is that you [name] will this afternoon be okay?’ Couldn’t believe the difference, you know.”* (Sutherland interview, patient 2)

There was only one suggestion for improvement made by one patient. They believed that the practice could be more proactive in visiting and monitoring house bound patients.

## **Likelihood and preference for providing feedback**

### **Davidson Practice**

#### *Likelihood to provide feedback*

Staff in Davidson Practice perceived that patients were highly likely to complain when unhappy about the service and that they were more likely than deprived patient populations to provide formal feedback.

Few patients however indicated that they would be likely to give feedback spontaneously. Only two indicated they would comfortably discuss their experiences direct with the practice and particularly not with any of the GPs.

*“ I don’t want to argue with the doctor....I just wanted my [dependant] to be seen, that was my main concern. I was just glad that she was getting something and she was being seen.... I mean there will be the odd person as everybody’s individuals who will quite happily say their piece while they’re there or complain, but I don’t think that’s the majority*

***So you wouldn’t say it directly to the doctor?***

*No. Would I heck!*

***What is that about?***

*Respondent: No. I don’t know, it is a doctor and they’re clever and I don’t know”(Davidson interview, patient 5)*

All patients indicated however that they would be happy to provide feedback if the practice requested this but had some specific preferences on how they might do this.

### ***Preferences for providing feedback***

All patients perceived that their experienced of the practice were important and that their feedback should be sought. Just over half of the patients (6/11) indicated that they would prefer to give feedback by completing a survey, provided it was short, or by being asked a few questions by receptionists at the desk. PPG members indicated that they would be most likely to raise issues at their meetings and when asked about the use of social media were very averse to commenting about the practice or individual doctors on doctors rating websites or facebook. Patients outwith the PPG members were largely unaware of the practice website and the one patient who was aware of it indicated they would be reticent on using the comments section because of their perception that any comments made could be seen by others. When asked about doctor rating websites, 2 of the 5 non PPG member patients said that they would consider using these to examine what others think of particular doctors although no-one interviewed was comfortable with posting on such sites.

## **Blair Practice**

### *Likelihood to provide feedback.*

Blair Practice staff perceived that patients would be very likely to provide direct feedback to practitioners if they were dissatisfied with the quality of the service and beyond this were relatively uninterested in the quality of their health service experience.

Only one patient indicated however that they would likely provide spontaneous feedback direct to the practice when they were unhappy with the service. All however indicated that they would be willing to respond to requests for feedback from the practice. One patient indicated that they would never give direct, non-anonymised or unsolicited feedback positive or negative to the practice for fear of either being struck off the practice register or for being labelled as either being 'trouble' or seeking favouritism (if they gave positive feedback).

*"...not negative stuff [feedback] as you don't know when they might just strike you off; and not positive [feedback]...in case it gets misinterpreted or seen as inappropriate."*(Blair interview, patient2)

### *Preferences for providing feedback*

Most staff believed that patients would be happy to provide suggestions or complain to the practice when dissatisfied.

Patients perceived that their experiences of the service were important and the practice could always learn how it could improve things by seeking their views. There were mixed preferences for how patients might give their feedback however. One patient indicated that if they had to give negative feedback they would prefer to do that face to face with their doctors. Two patients indicated a preference for their feedback to remain anonymous and the remaining patient said that they would prefer to speak to someone senior in the practice but were unaware of the roles there were in the practice.

In terms of giving more general feedback about the overall quality of service two patients indicated that they would be happy to interviewed by someone independent to the practice. Two patients said they would also be happy to complete short surveys if the practice sent these to them or asked them to complete them in the practice. One patient believed however that people were generally tired of being asked to complete surveys and wished to be left alone when at home.

*“Well, my thoughts on surveys, people, to be honest, are fed up with surveys....I don’t want people through the phone phoning my home for a survey. A lot of people will be like that. There’s too many surveys.”* (Blair interview, patient 4)

## **Sutherland Practice**

### ***Likelihood to provide feedback***

Sutherland practitioners differed to those in the other two practices in that they indicated that the patients may be uncomfortable with discussing dissatisfaction with their health care experience direct with those in the practice.

Patients were divided in how likely they would be to spontaneously provide feedback. Two patients indicated they would likely give feedback direct to doctors if they were unhappy. One indicated that they would not give any negative feedback and would move practice if unhappy. The other patient thought they personally would not give negative feedback direct and neither would most other people in the community:

*“My experience in this village is that people will chunter behind their backs, they won’t come out and say to the doctor look I don’t think you are doing this correctly.”* (Sutherland interview, patient 3)

### ***Preferences for providing feedback***

Staff in this practice perceived that patients would prefer to discuss their dissatisfaction with others in the community or provide anonymous feedback to the practice. One patient indicated that they

would raise any discontent with their GP directly. Others however, as staff perceived, stated preferences for more anonymous methods such as surveys. Two patients indicated they would be happy to join a PPG but did not see this as a vehicle through which they would raise their own personal dissatisfaction. Overall patients were uncomfortable with providing feedback direct. One patient indicated that if they were dissatisfied they would feel very uncomfortable with providing feedback in any format. They stated that in the past, when living elsewhere when dissatisfied they have moved to a different practice. They indicated that this would be their preferred course of action if they because dissatisfied however perceived that because they now lived in more rural location they could not easily move practice .

*"...just feel that here we really have not got a choice. When I lived in [town] we had doctors all round, you could pick and choose your practice and if you weren't happy you moved, I did, I moved. And I just feel we have not got that here, we are just a tiny little place....I wouldn't [speak up if unhappy], I would probably go home simmering. ...you just feel, me personally I feel am I going to get picked on the next time you go in."*(Sutherland interview, patient 4)

## Summary

Staff and patients' perceptions have been compared in this chapter. Patient interviews highlighted that patient experiences did vary across practices and that practitioners' perceptions of what patients' experiences were like were broadly accurate. Staff perceptions about how readily patients would raise concerns did not as closely reflect patients' reports in two of the practices – Davidson and Blair. It was only in Sutherland Practice that GPs indicated that patients might have reservations about telling them directly about their experiences or concerns. While this was the case with most patients, staff in the other two practices did not consider this as a key issue.

In all three case study sites most patients also had concerns about challenging medical practitioners or how any feedback they might give would affect their relationship with their GP and practice. A

minority went as far as stating that they would rather move practice than give any negative feedback.

Not all patients interviewed however had these reservations about providing feedback. Older male patients indicated that they would raise any concerns they had in person with their GP and appeared to have fewer reservations in doing this than others who were interviewed.

None of the patients had heard about the Better Together survey and regardless of the efforts a practice put into seeking feedback from patients most were relatively unaware of how they might provide feedback or the avenues open to them to do so.

All three practices tended to have relatively passive ways of gathering feedback – for example, suggestion boxes or books with no pro-active encouragement from staff to use them. It was only when Davidson Practice PPG ran their waiting room campaign looking for suggestions on how the practice might improve its services and placed a large poster with paper and pens and a temporary box for suggestions that they got a range of suggestions in a short space of time from patients.

There was no clear patient preference for providing feedback identified in any of the case study sites and in some cases patients contradicted themselves, indicating they would be happy to answer a few questions posed by receptionists but also stating a preference for anonymity.

Some patients talked of poor experiences but many highlighted their lack of willingness to raise it with their practice. They perceived that it was either not their place to challenge medical staff; were concerned that giving negative feedback might lead to experiencing future difficulties in using the service or were unaware of how and who they could raise their issues with.

Interviews with patients indicated that overall experiences did vary from practice to practice and many patients, regardless of how active a practice a team might be in seeking patient views had some reservations about providing feedback (positive and negative) direct to their practice or were unaware of how they might do this.

They also highlighted that staff's perceptions of how likely their patients would be to complain may not be wholly accurate. Patients interviewed in this study appear far less likely to complain direct to their practice or move practice than staff might believe. It was only in one practice that GPs recognised that this might be the case.

## Chapter 8 Discussion and Conclusions

### Introduction

This final chapter discusses the key findings from both the realist review and the realistic evaluation of the use of formal patient feedback in general practice. It also details the strengths and limitations of the study, details my personal reflections of undertaking the study and highlights the implications for practice and future research.

### Key Findings

#### *Realist review*

The realist review found ten studies that examined the impact of formal patient feedback in primary care teams. All studies focused on the use of patient survey feedback. Most studies reported that GPs had concerns about the validity of patient survey data and teams experienced significant barriers to acting on feedback or sustaining change. There was some evidence to indicate that with external facilitation and attention to how patient survey data were collected and shared that teams could be stimulated to initiate improvements in care. The positive skew in most patient experience surveys along with other methodological limitations was noted as making it difficult for teams to use survey results alone to identify which improvements to focus on or to demonstrate the impact of their improvement efforts. Overall, there was little or no evidence that such feedback led to actual improvement in patients' future experiences of primary care.

#### *Refinement of programme theory*

Findings from the realist synthesis were used to refine the policy informed programme theory and develop a Context, Mechanism, Outcome (CMO) configuration that detailed the specific conditions thought necessary for formal patient feedback to lead to improvements in patients' experiences of care (see Figure 5, page 49). This programme theory still had an overarching assumption that once patient feedback was perceived as valid by GPs, then improvement



efforts would be stimulated and such changes would lead to improvements in patients' experiences of care but additionally acknowledged the limitations of current methods in detecting changes in patients' ratings of their health care experiences.

### *Realist Evaluation findings*

Case study work in three Scottish general practices focused on understanding the extent to which the CMO devised from the realist review explained how teams responded to formal patient feedback in their day to day practice. Findings indicated that the gathering and use of patient feedback in general practices was different from that assumed in current policy or guidelines. Two of the three practices in this realist evaluation did little to gather formal patient feedback from their patients, and their only sources of formal patient feedback were complaints and a two yearly report from the national survey conducted by Scottish Government.

### *Beliefs and values about formal patient feedback*

Activity relating to the gathering of feedback and responses to it were found to be dependent on collective team beliefs and values. Staff over time developed assumptions about how good their patients' care experiences were and about patients' likely preferences for providing feedback about their care experience. Assumptions were similar within practices but differed between practices. Two teams did not perceive that the gathering of formal feedback was a priority but for different reasons. Blair Practice perceived from the low frequency of written complaints and the informal feedback they received from their patients in the day to day interactions with them that care experience was mostly positive and that patients would likely tell them face to face when since because response rates to the national survey were low and their patient group's literacy levels were so low they perceived that patients would be unlikely to engage with providing written formal feedback. Sutherland Practice did not view it as a priority because they perceived that care experience was mostly positive based on receiving very few verbal or written complaints and very positive national survey score. Unlike Blair

practice they perceived that their patients were very articulate and well educated and would likely engage in providing formal feedback and that there was a possibility that some patients may be dissatisfied but uncomfortable in giving such feedback direct to the practice. They had not previously engaged with gaining formal feedback but after receiving an unexpected low score on one item in their national survey they actively sought support from their CHP with establishing a patient participation group. Davidson Practice was the one practice that did perceive the gathering of formal patient feedback as important and did engage in seeking and responding to formal patient feedback in a range of ways. This was because they perceived that patients would readily complain and had evidence of frequent complaints that substantiated their collective belief. They also perceived that their patients had high expectations of the service and were likely to respond to requests for formal feedback. Lastly, but importantly, they also had a committed practice manager who was passionate about ensuring positive patient experiences.

The majority of practitioners perceived that the national survey or other forms of formal feedback produced invalid reflections of the experiences of the majority of people who access their service. GPs and practice managers perceived the national survey to have significant limitations. Most were unsure of how frequently it was conducted and the majority were concerned about the sampling approach used, some of the wording of questions, its previous link with QOF payments and the lack of adjustment of survey scores for socio-demographic factors known to affect patients' ratings of their experiences of health care. The majority also expressed a dislike of the use of a national comparator in survey reports, perceiving this to be unhelpful and unfair.

GPs in this realist evaluation had similar concerns about surveys to those reported elsewhere (154, 167, 168) and had an equal amount of concerns over most other forms of formal feedback. Prior to their introduction, a national study indicated that the rigour of the Scottish GP and hospital surveys was deemed critical to their acceptance and usefulness (97). Similar to

GPs in England (168), most GPs and managers in this study did not perceive the national survey to have sufficient rigour and perceived it to be a political tool designed to control their funding, even after discretionary payments linked to survey scores had been removed. GPs in both studies also considered respective survey sample sizes to be unrepresentative, believed samples could potentially include patients who had little knowledge of the practice and GPs were concerned about the lack of adjustment of survey scores for socio-demographic variables they perceived to affect patients' expectations and subsequent ratings of their service.

It is not understood how findings from this study reflect the views of GPs across Scotland towards the formal patient feedback. The Scottish Government have been reported to have undertaken a review to explore users (health care providers) experiences of using the Scottish patient experience survey statistic however, it is not clear who they sought feedback from. Despite being required to publish these findings by the UK Statistics Authority in 2011(118), at the time of writing, no such report could be sourced. However, it is anticipated that the views of GPs in this study about the Scottish survey are likely to be broadly reflective of those of other GPs in Scotland and if anything views about formal patient feedback might be slightly more positive because two of the practices were purposively sampled to be the more 'active' in gathering and/or responding to formal patient feedback. The findings from this study indicate however that even when 'active' general practices are examined, views towards formal patient feedback and responses and activity following receipt of such feedback does not reflect the programme theory. In addition, findings from this study relating to views about surveys also broadly reflect those of the recent English study cited above (168) and of a recent study exploring the views of UK GPs about the practitioner specific patient experience surveys used in their appraisal and revalidation (66).

Collective concerns amongst GPs about poor response rates and perceived negative response bias to the national surveys in use in the UK do not necessarily reflect recent empirical evidence about the technical performance of such surveys. Statistical analysis of practice level patient

experience survey results reveals that, at least in England, there appears to be no evidence to indicate that low response rates and selective non-response bias have led to systematic unfairness in payments attached to the patient questionnaire scores (169). This is not information however which GPs are routinely exposed to and views of GPs and practice managers in Scotland (and elsewhere) are unlikely to significantly change until such evidence is shared and discussed widely with GPs and practice managers.

Thatwithstanding, the concerns that all practices had about feedback being mainly provided by white, middle class, educated patients is an important finding. As discussed in the introduction and methods sections, a number of studies have highlighted the inequity that exists in research participation and data collection in clinical trials and in qualitative research studies with many minority groups' voices being under represented (52, 143, 144). As there are a significant numbers of these so called 'minority groups', the notion of 'minority' is questionable when applied to all the people who may be excluded. Research into this area has highlighted how the methods used to both recruit and conduct health service research can alienate certain sub groups in our population and most often those individuals that are in poorest of health (48, 170). Research has also highlighted that in addition to the socio-economic influence on health the ways in which health care is delivered can also influence how health care is accessed and used and thus has the potential to further inequalities in health (171, 172).

Increasingly, addressing the inequalities gap is regarded as a social justice issue and is of increased importance as significant cuts in welfare and health care provision are occurring during this period of austerity in the UK (173). Engaging effectively with all groups in society to understand their needs, experiences and evaluations of services is therefore critical if health and social services are to be designed to more effectively address the widening gap between the health of the wealthiest and poorest communities (inequalities gap) in the UK (173). It is therefore necessary that further research is undertaken with specific minority groups to best understand how their voices can be heard in the service improvement and health and social policy agendas.

In addition to this it is evident from the findings of this present study that there is also work to be done to shape attitudes of health personnel towards the feedback given by minority groups. Credibility of patient feedback in the eyes of practice staff was a significant influencing factor determining how each practice reacted to patient feedback and the efforts they made to engage with their patient group about their experiences of general practice care. It was also evident that credibility was not purely based on what patients said or how ratings compared with practitioners' own beliefs about the quality of service. Particularly in Blair Practice credibility judgements were also related to the method used to gather feedback and its fit with their patient population characteristics. For example, the Better Together survey was largely dismissed as irrelevant by the Blair Practice GPs and staff because they knew that many of their patients had low levels of literacy and would not complete it. While true, this fails to recognise that the feedback of those responding might still be useful. More tailored methods were seen as necessary but viewed to be time consuming and difficult to achieve while managing the disease burden associated with this population group. Further research in this area to explore how experiences of patients belonging to different population groups can be most feasibly and effectively gathered is needed if we are to better understand and address their needs.

### ***The role of informal patient feedback***

The programme theory assumed that perceptions of validity were central to responding to patient survey results, but in the three case study practices perceptions of validity seemed only weakly related to whether or not practices engaged in improvement activity. In Davidson Practice for example, the majority of clinical staff openly critiqued the validity of the survey but continued to consider their survey scores and their implications for practice. This was because decisions to engage in improvements aimed at enhancing patients' experiences were made largely in response to more informal feedback given by patients. It was the day to day interactions with patients that informed the views and beliefs that practice teams collectively

had about their patients, their patients' views of the service, views of individual practitioners and their preferences for providing feedback.

A 2008 review of patient feedback activity in Scotland (97) highlighted that most practices used GP surveys as their main source of feedback. However this realist evaluation has shown that while this may be what is formally reported, in reality some practices use other methods such as complaints, PPGs, suggestion boxes and website feedback to understand their patients' experiences and practitioners individually and collectively use other, less formal cues to estimate patients' views of their service more than survey data.

Similar to that reported elsewhere (79, 97), practice staff and GPs, interviewed in this study tended to report a preference for both quantitative and qualitative patient feedback. Although formal qualitative data such as patient stories and complaints can be useful, particularly for improvement, this study found a predominant reliance on informal qualitative feedback given directly to practitioners by patients. Such data have been found however to mask dissatisfaction. Consistent with other research(174)(40)patients interviewed in this study reported that they tended to provide mainly positive feedback direct to practitioners and avoided giving negative feedback. Patients have also been reported as often mitigating poor experiences by accepting failures in systems and performance as inevitable and scoring overall satisfaction on survey even when they had some poor experiences. Most patients state a preference for providing both positive and negative feedback anonymously (40, 41).In contrast, GPs and other staff in this realist evaluation were found to be relatively accurate in their qualitative estimates of patients' views of the service when compared with patient survey results, complaints and patients' qualitative evaluations provided in interviews. In each practice, when patients' evaluations of the service were asked for in interviews, their evaluations and the things they valued most were consistent with what staff had said in interviews when asked to estimate what their patients would likely say about the quality of

service they received. Ease of access to appointments, continuity of care and the friendliness and helpfulness of staff were the most valued aspects of the service by patients.

Similarly, other studies have reported that GPs can be relatively accurate in their estimates of patients' evaluations of the quality of doctor consultations(175) and it has been suggested that doctors can be sufficiently motivated to change practice in light of their own perceptions of care (176). Some might surmise from this that asking patients about their experiences and evaluations of their care experience has limited added value, particularly if doctors are so sceptical about the usefulness and validity of patient surveys. Doctors' and patients' evaluations of care have however been found to not be identical on all aspects of care (175),(177), particularly in relation to judging the experiences of particular groups such as young mothers and ethnic minorities (177) and findings from this realist evaluation indicate that some patients do have poor experiences but fail to raise it with their practice. It would appear therefore that there is still a place for formal patient feedback as such feedback still has the potential to highlight quality issues not immediately apparent to service providers.

#### *Staff responses to formal patient feedback*

Activity relating to acting on formal patient feedback varied across the three practices. One team paid very little attention to their national patient feedback in the wider context of having few meetings or processes designed to monitor or consider the quality of service provided by the practice. Another, which had structure and processes that supported them to regularly consider the quality of service they provided, established a patient participation group to try and better understand their patients' experiences after some unexpected findings in the national patient survey. The last practice which was both actively involved in gathering and acting on formal patient feedback beyond the national patient survey had in addition to effective structure and processes, an enthusiastic practice manager with a personal commitment to enhancing patients' experiences of care.

Consistent with findings from the realist review provision of formal patient feedback, survey data had little or no impact at practice level. Findings from the review suggested that validity concerns and issues associated with the timeliness and nature of patient experience data can act as a barrier to staff acting on patient feedback (108, 133, 153). This study of 3 general practices found that although similar concerns were expressed, none reliably predicted practice staff actions in response to patient feedback. GPs and practice managers appeared instead to be engaged in a more cyclical and iterative process of reasoning similar to that which occurs in a process that Gabbay and Le Mays(178) have called 'mindlines' and Checkland (179) has called 'sense making'. GPs and practice managers' reasoning informed the extent to which they sought and responded to patient feedback. Like 'mindlines' or 'sense making', decision making was messy and vague and built from knowledge from a wide range of sources. It was practitioners' collective beliefs about how patients preferred to provide feedback, and their sense of patients' levels of satisfaction that determined if they perceived a need to gather formal feedback or improve patients' experiences largely irrespective of what their survey data indicated. Their collective and individual beliefs were informed by their day-to-day interactions with each other, with their patients and their previous experiences of collecting, receiving or responding to feedback as well as other indicators of quality they routinely measured. They predominantly used informal feedback to collectively make sense of their world, and to reinforce and internalise their individual and collective perceptions of the quality of care and care experience and their patients' likelihood to be interested in or willing to provide patient feedback. Reasoning in response to formal feedback was therefore more of a continuous, cyclical process, influenced by the historical and current contexts of general practice teams rather than the linear process depicted in the CMO or the programme theory. Patient survey data therefore did not appear to act as a key stimulant for change as assumed in current health policy.

This finding is significant in that it questions the appropriateness of assessing the impact of patient feedback as an indicator of quality in isolation from other quality indicators and quality



initiatives or policy or contractual requirements that clinical and managerial staff continually use to consider if, how and to what extent they need or can change the status quo. The reality of general practice is that there are always a number of drivers for change and therefore most practices are likely to be fairly continually engaged in one or more quality improvement initiatives. It may be more useful in the future to consider the role patient feedback plays in decisions about quality improvement priorities and subsequent improvement activity and outcomes. A systematic review of studies that explored the effectiveness of continuous quality management in clinical teams has highlighted that interventions greatly vary and while single site studies have shown some effect, randomised controlled trials have shown no effect (180). Further research into this issue would therefore be helpful in shaping how patient feedback, along with other indicators of quality, can best support improvements in care outcomes and care experiences.

#### *Demonstrating improvements in patients' experiences of care*

The Scottish Better Together Patient Experience Survey was limited in its ability to identify the impact of changes in practice. The survey produces, like others, positively skewed results and is only conducted every 2 years. It was therefore perceived by GPs and other general practice staff to have limited utility for driving improvement and as stated previously, staff tended to use other more informal feedback and internal audit data to determine the impact of their efforts. Case study observations also found that even when significant efforts are made in response to formal feedback unanticipated changes in context such as staff shortages and introduction of competing, externally imposed targets limited the impact of improvement efforts.

Similar to the findings of Davies et al (2008) (152) this study found that some teams do engage in improvement efforts in response to patient feedback, but despite significant effort, find it difficult to positively impact on patients' experiences of their care and thus some were somewhat demoralised. This is consistent with findings reported elsewhere that patient

feedback can have a negative effect on clinicians' morale (154) and that quality improvement initiatives more generally often have unanticipated negative effects on staff (181).

## **Implications for policy**

### ***National survey purpose***

It is unlikely that the use of the national survey of general practice will disappear from the consumer focused quality assurance landscape any time soon. If opinions of the national survey are to change then key methodological issues need addressed. Most importantly it is crucial that the purpose of the survey is clarified. Currently it is portrayed by Scottish Government to have a dual purpose. It is 1) used to compare NHS performance, and 2) expected and reported by Government to be used by NHS services to guide improvement (118). This is despite a lack of strong evidence to indicate to what extent the latter takes place. Its'perceived ability to support improvement is limited however by it only being carried out every 2 years, some of its content, perceptions about its sampling and response bias and the publication of survey scores unadjusted for socio-demographic variables.

### ***National survey reports***

A recent review of the Better Together survey data by the UK Office of National Statistics (118) reflects some of the concerns raised by practitioners in this study and also calls for the rationale for the use of particular weighting procedures to be made clear and data relating to non-response bias and other main sources of bias to also be published. Staff in this realist evaluation frequently stated their belief that their patients were different to other practices and that the provision of comparative data from similar sized practices or demographically similar practices would be more meaningful and help them understand the extent to which they needed to improve. There is evidence from the Scottish survey (80) and other studies (82, 182) that indicates that patients attending larger practices report poorer experiences, particularly of access and continuity of care. Work undertaken previously in this Scottish region supported the

comparison of individual practices' QOF performance with regional, similar sized and demographically similar practices. However this wasn't because comparisons with similar practices usually made much difference to how practices were ranked in terms of performance. Rather NHS Boards found it helpful to have different comparisons available to deal with the common response of "our practice/patients is/are different" in facilitated discussions about quality (183). Provision of patient survey data with a range of comparators such as this or with adjustment of scores for socio-demographic variables could therefore go some way to reducing this initial barrier to paying attention to the national patient experience survey scores.

### ***Frequency of national reports***

Some authors have suggested that improvements in individuals or teams, although likely to be small to moderate are more likely to occur when feedback (relating to a range of areas of performance) is intensive (63);(116). While the realist review found little to no evidence to verify these claims in relation to patient feedback it is suggested that the current two yearly frequency of the national survey is inadequate if the government are to continue to promote it as a tool that can and should stimulate improvements.

Evidence about quality improvement more broadly would suggest that when practitioners engage with collecting their own data they are more likely to proactively make improvements(25, 181). Evidence from this study however highlights that GPs already feel they have little time to address all aspects of their role and most indicated little time to pay attention to the feedback they currently receive. A recent evidence scan also suggests that for patient feedback to be used routinely in practice the burden of its collection should not sit with frontline staff (90) and significantly, there is also no evidence to indicate that any more attention was paid to patient feedback when practices collected this data themselves or that such feedback was any more effective in transforming patients' experiences of care (113, 133, 149, 150). It is therefore not recommended that a return to the previous patient

experience QOF arrangements would significantly support practice teams to successfully address this aspect of quality.

### ***Engaging GPs in changing national survey***

There is evidence to suggest that practitioners are more likely to engage in quality improvement efforts when they have been engaged in determining the goals of improvement and in how they will achieve and measure improvement (184). Being involved in patient survey development has also been found to enhance practitioners' faith in the data it produces and reported to support teams to quickly identify areas for improvement (108, 152). Engaging GPs in updating the survey content, determining the optimal frequency for the survey to be conducted, agreeing the ways in which data are reported and providing the opportunity for practices to ask questions of issues salient to them in addition to core questions should therefore all be considered.



### ***Revising the CMO***


Findings from this study have highlighted that the extent to which general practices engage in patient feedback is significantly influenced by the context in which practices operate and the type of feedback they receive.

Findings from the investigations into what happens within and across 3 practices has highlighted divergence from the proposed CMO. These have been discussed in detail previously but are now highlighted in red in final iteration of the CMO in this study.



**Refined CMO**

Context +	Mechanism(s) =	Outcome
<p>Practices:</p> <ul style="list-style-type: none"> <li>are resourced to provide good patient experiences</li> <li>view patient experiences as a key quality outcome and</li> <li>have access to timely patient feedback data</li> <li>are structured in ways that supports improvements to be readily implemented</li> <li>have access to data that are capable of detecting small changes in patient experience</li> <li>have access to feedback that has been gathered from whole and relevant sub –populations using appropriate methods</li> <li>have leadership with a strong commitment to continual improvement in patients’ experiences</li> <li>have received patient experience data that demonstrates room for improvement</li> </ul>	<p><b>Stage 1 Reasoning 1 :</b></p> <p>When faced with formal patient feedback, teams collectively believe:</p> <ul style="list-style-type: none"> <li>patient feedback is credible</li> <li>formal feedback aligns with cumulative views of patient experience gathered from informal feedback from patients</li> <li>that patient experience is worse than in a reasonable set of comparator practices (for example, demographically similar, similar sized and/or nearby practices).</li> <li>that feedback is for improvement and not external judgement</li> <li><del>data are presented in easily understood ways that meet GP preferences</del></li> <li>improvement is possible</li> </ul>	<p>Changes in practice are detected in future patient feedback scores and/or other indicators of quality</p>
	<p><b>Mechanism 1</b></p> <p>Team decide to try and make improvements</p>	
	<p style="text-align: center;"></p> <p><b>Stage 2 Reasoning</b></p> <p>Teams:</p> <ul style="list-style-type: none"> <li>acknowledge that patient feedback is consistent with what staff already see as improvement priorities</li> <li>find a strategic fit between organisational priorities and patient feedback informed improvement priorities</li> <li>perceive the changes to be sufficiently important to allocate resources to</li> </ul>	
	<p style="text-align: center;"></p> <p><b>Mechanism 2</b></p> <p>Team use tight management controls to ensure changes are integrated into their overall quality improvement activities and adjust/ reinforce ways of working as impact is tracked.</p>	

	<b>Mechanism3</b>  Team find ways to sustain changes in practice	
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This CMO provides a useful starting point for further research into how and why patient feedback may support quality improvement but is also useful for shaping future intervention work as it synthesises the main considerations that need attention in future work relating to the use of patient feedback in general practice.

## Implications for Practice

### ***Patient Participation Groups (PPGs)***

The findings from this study indicate PPGs can play an important role in informing practices of where improvements can be made, although this is likely to require support from a committed practice team member. GPs in England have been encouraged through a directed enhanced service to actively engage with patients by establishing patient reference groups (185). Patient comments from this realist evaluation indicate however that their acceptability in all patient populations still needs to be tested and that their establishment in a practice needs to be guided by local knowledge as well as the generic guidance (15, 186, 187) that is available to practice teams. Furthermore, consideration needs to be given to how best to provide appropriate facilitation for patient members and practice staff (although as in Davidson Practice, this could be achieved internally) and the time and effort it takes to keep them vibrant. The support patients need to actively represent the practice population in ways perceived to be valuable by them and the practice team should not be underestimated.

### ***GPs need convincing of the added value of survey feedback***

More fundamental than what or how patient feedback is gathered is the need to convince some GPs that gathering and examining formal patient feedback, particularly using patient surveys is a useful quality improvement strategy and one that would “tell them anything different” from the informal feedback they routinely receive from their patients. Findings from this study indicate that much of what is indicated in patient survey feedback is already understood by practitioners. It is unlikely that the collective ‘mindlines’ held by practice teams about the need to gather formal patient feedback will be changed unless future research or survey data indicates a distinct difference between practitioners’ estimates of patients’ evaluations of care and patients’ quantitative or qualitative evaluations.

Furthermore, the positive skew on most patient surveys and indeed the Scottish survey potentially makes it difficult for staff to demonstrate the impact of any improvement efforts therefore, more sensitive quantitative tools are needed if GPs are to be convinced that patient experience surveys are useful tools for improvement.

### **Feedback of findings to Practices**

Following the completion of the study I offered each practice a feedback report or presentation. The two more active practices (Davidson and Sutherland) invited me to present at their practice meetings while the practice manager in Blair requested a short report, indicating that it was unlikely that the GPs would have the time or be sufficiently interested in the results to attend a meeting. Presentation of findings to the other two practices was a positive experience. Davidson GPs indicated that they “could see themselves in the findings” but stated that it had made them think about the unconscious biases they perhaps had to patient feedback data from different sources e.g. favouring complaints data even if only provided by one patient over survey data or PPG data that sometimes had been given on repeated occasions. It also raised for them an insight into the opinions of their PPG and how the lack of a GP attending their meetings was being perceived. GPs and the practice



manager indicated at this meeting that they would consider this latter point and look to find a meaningful and feasible (one that did not take them away from seeing patients for too long) way for GPs to directly engage with the PPG.

Sutherland Practices responses were similar in that they too “could see themselves in the findings”. Discussion about their sources of data also appeared to stimulate them to reconceptualise village rumour data as a potential asset to be drawn upon rather than something of a minor nuisance or irritant. GPs in this practice had established a PPG just as data collection was completed and fed back to me the difficulty they were having in establishing the group’s purpose or a specific piece of work they could take forward. They believed that sharing of the findings from the study would be most helpful in stimulating that discussion.

There was a short phone call response from the practice manager in Blair Practice to say they had moved their suggestion box to a more prominent position in the practice but they also indicated that they anticipated it unlikely that this would change the volume or nature of suggestions they received.

Some researchers have advocated respondent validation as a way of enhancing credibility of qualitative research (188). Such an approach has more recently been seen as problematic as the perspectives and agendas of the researcher and participants will to a greater or lesser degree be different and synthesised findings will necessarily look different to participants’ substantive accounts and therefore comparisons are inappropriate (189). Findings from this study were therefore not shared with participants to enhance rigour but instead as a way of ensuring the research partnership was concluded in accordance with agreements made at recruitment i.e. to report individual practice findings to each team following analysis. The process of summarising data for each practice, however, helped further assess the credibility of conclusions drawn from each case study. Meetings to feedback or follow up on the provision of a report took place following first thesis submission therefore the data

presented in this paragraph were not part of the analysis. Responses reflected the expected pattern in each practice which adds further credibility to the conclusions drawn.

### ***Patients' awareness of how to provide feedback***

The current reliance on direct and informal feedback is likely to be masking some dissatisfaction amongst patients, even if more informal feedback does sometimes stimulate improvement activity. Patients in this realist evaluation study reported a lack of willingness and awareness on how to report poor experiences of care. At worst, some patients had experienced poor experiences but believed that they had little opportunity to complain or move practice or were unaware of how they might do so. There is therefore a need for the Patient Advice and Liaison Service, established by the Patients' Rights (Scotland) Act to be more widely communicated to the general public and for practices themselves to make patients more aware of how they can provide both positive and negative feedback.

### **Implications for research**

This study has highlighted significant variance in how formal patient feedback is gathered and used in general practice. Practices were purposefully selected from two ends of a range where at one end, practices very 'active' in seeking patient feedback and engaging in patient experience focused improvement activity and at the other, practices were 'active' or 'less active' in this respect. It is unclear however how practices across Scotland are distributed across this range and a survey of practices across Scotland would help ascertain the extent to which practices are engaged with gathering and responding to patient feedback. Engaging practices in this study and others (149) was however difficult as this topic did not appear to be of key importance to most practices that were contacted and many practices indicated that they were too busy to take part. Findings show however that practice managers play a key role in sharing the national survey results with GPs and/or other staff and/or in leading or coordinating the gathering of formal patient feedback on behalf of GPs. It is suggested

therefore that a very short survey, administered by email to practice managers would be helpful. Such a survey should focus on identifying if the practices use other surveys (apart from the Better Together and those used for appraisal) to routinely collect feedback, if they have a PPG, if they have a suggestion box, if they routinely seek feedback through waiting room comment and suggestion campaigns or through their website and if they can describe one or more improvement activities implemented in the previous year in response to such feedback.

The examination of one PPG within this study highlighted a range of views within the practice about its usefulness and purpose, and a number of contextual features that affected its possible role within the practice. Further research is required to understand the acceptability, feasibility and utility of PPGs in general practices set in a range of practice populations, and to better understand what it takes for a practice and interested patients to make a PPG effective and sustainable.

Practitioners in this study continually criticised the lack of useful comparators in national survey reports and perceived that this influenced their willingness to pay attention to their practice results. Observations highlighted however that perceptions of the survey had little influence on improvement activities or decisions but further research, exploring the use of comparators deemed acceptable to GPs and practice managers and /or adjustment of survey scores for socio-demographic variables would increase our understanding of how such changes influence views of the national survey and if a change in views increase the extent to which practitioners act on their survey feedback.

This study also indicated that a highly skilled practice manager was pivotal in stimulating change efforts in response to patient feedback, even in the most active practice. There is therefore potential to study how the development of quality improvement skills of practice managers or other committed individuals working in general practice can influence the impact of patient feedback.

## Limitations

The inclusion of only three general practices in Scotland means that generalisation of findings to other practices, particularly those working with different commissioning arrangements and operational pressures should be cautious. The three practices were purposively selected on the basis of their location , practice size , socio-demographic characteristics of patient population and in particular in terms of the extent to which they are engaged in gathering and responding to patient feedback where the aim was to sample from the most and least active. Other research (97) would suggest that Davidson practice is not necessarily typical of most practices and therefore if significant attention was to be paid to the national survey results or other formal feedback then it is likely it would have happened in this active practice. It is unlikely therefore that there is widespread attention being paid to formal patient feedback although of course, it is impossible without further research to confirm this claim. Similarity between views about the national survey expressed in this study and that of GPs in studies included within the realist review and another recent UK study (168) further indicates that views towards the national patient survey drawn from these detailed case studies are likely to have some general relevance.

Originally, it was planned that general practice staff from across Scotland would be surveyed to gain an understanding of their views and (reported) use of patient feedback and this data would be used to purposively select practices to take part in the case study. The lack of a standardised survey and the ambiguity surrounding definitions of what constituted patient feedback at the outset of this study combined with a lack of time made this unachievable. A survey of practices across Scotland would usefully contribute to understanding how practices more generally formally and informally gather and use patient experience data.

Much of the contextual influence on patient feedback was found within the practices themselves, but the impact of attempts to improve patients' experiences was to a greater or lesser extent influenced by the external context in which practices work. The

needs of the local communities that practices served, how patients gave feedback to the practice, and the wider health policy and drivers all were seen to influence attitudes and views about feedback methods and the extent to which feedback was acted on. A decision during field work in each study highlighted that practices did not perceive that CHPs influenced what they did in relation to patient feedback activity and therefore no interviews were undertaken with CHP staff. However it was found on return to Davidson Practice to establish the impact of changes commenced prior to completion of data collection that targets set by the regional health board did have an influence on the impact of this practice's efforts to improve patients' experiences of access to appointments. Therefore exploration of professional and managerial discourse between different organisational levels (health boards, CHPs and general practices) in future research might help further illuminate how sustainable improvements in patients' experiences can best be achieved.

The lack of mechanisms in place to gather routine formal feedback within practices limited the ability to explore patients' experiences of providing feedback to their practice. Patient interviews therefore focused on their experiences of the practice and their preferences for providing feedback. Due the small numbers of patient participants and lack of random sampling, the distribution of preferences for providing formal feedback would need to be ascertained through a larger study.

## **Strengths**

Prior to this study there has been no structured literature review of the impact of formal patient feedback in general practice. Studies included in this realist review that examined the impact of formal patient feedback have either been intervention focused or been limited by only using staff reports of their experiences of using patient feedback to understand the process of use and impact. This realist review also sought to systematically examine the range of factors affecting the use and impact of practice and practitioner level patient

experience data and therefore provides a useful addition to what is known about how and why formal patient feedback impacts general practice care.

The realist evaluation using detailed case studies has also gone beyond staff perceptions of patient feedback and by examining the everyday world of general practices through detailed observations of staff, uncovered the important role that staff's collective beliefs and values play in determining the impact that patient feedback has on practice; the complexities involved in trying to address quality issues in general practice and how current methods and approaches to measuring patient feedback limits the ability of practice teams to understand the impact of their improvement efforts. It therefore provides a rich and detailed understanding of the processes involved in collecting and responding to patient feedback.

This study also included reception and administrative staff where others have not and by doing so, highlighted how little this group of staff are aware or exposed to patient feedback that relates to the services they specifically provide. However, as was seen in Davidson Practice, reception and administrative staff could be actively engaged in making improvements aimed at enhancing patients' experiences, highlighting the potential for the inclusion of this group of staff in future attempts to improve patients' experiences.

A key strength of this study is the rigour with which it was undertaken. A systematic, realist review informed the development of a theoretical framework (proposed CMO and programme theory) that guided the research process. The comprehensiveness of case study research can be limited by access to data however access to data in each of the practices in this study was extensive and included access to all practice meetings including private partners' meetings and access to all documents requested. Triangulation of interview, documentary and observational data and the use of the constant comparative method within and between practices also enhanced the rigour with which conclusions were drawn.

## Methodological critique

The use of realist evaluation provided me as a novice researcher with a clear outline by which to conduct the study, but I found it difficult to find much written guidance on how to apply it into the context of studying general practice. In addition, Pawson and Tilley (122) provide little guidance on how to examine context and its influence on mechanisms (190) and it was therefore necessary to look for an organisational framework and a methodological approach to support a structured examination of the context in each practice.

The use of organisational frameworks in realist evaluations has been noted as posing difficulties however, as they are complex and causal entities on their own (135). I therefore looked for a model that supported the examination of each practice context through as wide a lens as possible, and one that refrained from making predictions of behaviour and performance of organisations based on their typology. I chose Schein (136) to fulfil this requirement. While the use of this organisational framework was useful in structuring data collection it made the analysis extremely complex. “Layers” or “views” of the organisation were being examined to reach judgements on what they individually and collectively told me about how and why each organisation operated in particular ways. At the same time I was also looking and examining specific mechanisms that occurred or were reported as having occurred in response to various moments when patient feedback had been received.

In addition to the consideration of these entities I was also considering the context in relation to professional groups existing in the practice (e.g. how and why nurses think and operate in particular ways, how and why reception staff think and operate in particular way, how and why doctors think and operate in particular ways etc). From a pragmatic point of view (too few staff in each professional group existed to make any robust or transferable comparisons) this eventually led to composite “views” of each practice context being developed. This is however different to the aspirations of realist evaluation to uncover the

“basic” elements of context as a road to unpacking the “white box” in which interventions work or not(135). Furthermore, Pawson and Tilley talk about the reciprocal relationship between mechanism and context. Even during this longitudinal study that examined responses to feedback in detail and in not insignificant periods of time, it was not always possible to find any changes in context in response to mechanisms fired by the intervention(patient feedback) and subsequent influence of such contextual changes on future mechanisms and outcomes. The reality of funded research and evaluationoften demandsrelatively short periods of data collection and therefore any examination of changes in context and their subsequent influence on mechanisms and outcomes will be likely to be solely dependent on stakeholders’ accounts and interpretations of historical events alone rather than observational data over time. The meaning and operationalization of the concept ‘context’ and how this can best be used to identify and adjudicate CMO configurations therefore requires further testing and description if the consistency and quality of realist evaluations are to be enhanced.

A recent review of realist evaluations in health care research shows differences in interpretations of methodology and how to best differentiate between context, mechanisms and outcomes(191).This was also an issue for me throughout the research process. The delineations between context and mechanism are not always clear cut and neither was it always easy to delineate between mechanism and outcome. What was perceived as an outcome of an interaction with an intervention could also be interpreted as a mechanism that influenced a more distal outcome. Perceived validity of survey data is a good example of this. It could be perceived as an outcome in one process - the survey data are shared with the practice team (intervention), the practice consider its validity (mechanism) in light of their tacit knowledge (context) and judge it is valid or not (outcome). Alternatively it can also be perceived as a mechanism that occurs in response to the survey feedback. Teams can receive their survey feedback (intervention) and perceive it to be valid (mechanism – reasoning) and engage in improvement efforts (mechanism- action) that lead to changes in



patients' experiences (outcomes). This caused much deliberation during data analysis and there was much debate in supervision about what constituted C, M and O. In practice there were a number of sequential CMOs taking place at the individual and practice level. While I recognise that a more descriptive data analysis process may have ensured that all of the other examples of improvement seen in Davidson Practice found their way into the written findings I believe that using realist evaluation and the constant comparative method ensured that they were taken into account during the process of data analysis and by choosing exemplars, a robust critique of current policy using rich descriptions and detailed analysis provided useful insights for policy makers.

Realist evaluation supports you to do a focused case study through a particular lens and as with all lenses it potentially limited my ability to consider the relevance of other explanatory theories. Its focus is on contexts, mechanisms and outcomes and as such less emphasis is placed on roles, power, relationships and language and so forth. Using other approaches such as social constructivism or discourse analysis, may have illuminated more about the dynamics of each team and their collective knowledge. I consider however that using a pragmatic realist evaluation allowed for the examination of observable social processes as well as examine how the social environments within which staff worked influenced and were influenced by external targets, staff and patients. By keeping such focus, realist evaluation was sufficiently broad and deep to support a robust examination of the extent to which assumptions about the role patient feedback can play in quality improvement are upheld in practice and has ensured the salience of findings for both policy and practice.

Undertaking realist evaluation using case studies in three practices generated large amounts of data. This was initially difficult to manage, but the development of a coding framework and a degree of pragmatism ensured that all sources of data relevant to the research questions were included. The volume however restricted more detailed analysis of issues that were somewhat tangential to the main research questions but nonetheless important in

health care. A further more detailed analysis of data relating to how the PPG operated in Davidson Practice for example would deepen our understanding of how PPGs operate, the support they need and the pitfalls that other practice teams might avoid and this is an aspect of the data that I would like to explore further. Observational data and documentary analysis contributed significantly to the volume of data. It was necessary to examine each source of data separately. This allowed for conclusions to be drawn from each prior to creating an integrated analysis of them to understand what it told me about the context, the mechanisms and the outcomes. This led to the development of multiple proposed CMOs throughout the collection and analysis processes that were difficult to adjudicate between without considerable “to-ing and fro-ing” between summarised and raw data and between individual feedback moments within and between cases. This process ultimately enhanced the rigour of the analysis; however it was very time consuming and complex.

This study has provided a rich and detailed insight into how three practices viewed and used patient feedback. As stated earlier, I had hoped, at the outset of the study, to have conducted a survey of all GPs across Scotland and to have used this data to purposively select practices to take part in the case study but this was not possible. As a result I have been unable to understand the extent to which what happened in these three practices is representative of practice norms elsewhere and have restricted my research experience to qualitative research skills. I therefore plan to continue to work in health service research, particularly in health service evaluation but recognise a need to gain further experience of quantitative data collection and analysis skills.

Although I came to this study with a long history of quality improvement in health care I had no experience of general practice. Because of this it took considerable time to understand the historical and contractual context within which individual practices operated. My lack of experience of general practice had both advantages and disadvantages. Recruitment to the study was delayed for a few months while I gained sufficient knowledge to be able to

construct my methods appropriately and feel confident to engage with practices. Once engaged in fieldwork, lack of knowledge of general practice meant that I spent large amounts of time understanding how practices worked before being able to focus on how patient feedback and experiences featured in their everyday practice. Although time consuming this also acted as an advantage as it ensured I looked widely, across numerous processes for instances where patient feedback was considered and was not constrained by any prior knowledge or expectations about where I might find patients' experiences being discussed. I also believe that having no connection to general practice meant that practitioners opened up significantly with me, particularly as the time I spent in each practice increased. It was through the trust I built with staff that I got to hear the 'real' feelings GPs and staff had about patient feedback and got to the 'unedited' reactions they had to patient feedback and thus got beyond their espoused beliefs.

Lastly, I have continued to work part time as a practice development nurse throughout the PhD and although I was involved in various initiatives aimed at improving patients' experiences at the outset, this was predominantly at a practice level. Undertaking this study has influenced my role in clinical practice in significant ways. My wider research skills and knowledge has changed how I approach practice problems or evaluation of practice development and my subject specific knowledge has led to me being involved in shaping my NHS Board's approaches and policies relating to gathering and using patient feedback. The knowledge gained through undertaking this PhD has ensured that some of the pitfalls in relation to the gathering and use of patient experience data are being avoided in current approaches being designed in my local Board area and my involvement in educating senior clinicians is shaping how clinical staff gather and use their patient feedback within continuous quality improvement.

## Conclusion

Patients' experiences of health care are likely to remain of health policy importance for many years. The gathering of patient feedback and the engagement of practitioners in general practice quality improvement are complex issues and require sophisticated, mixed method research approaches suitable to the real world of practice if we are to improve our understanding of whether they do deliver improvements in patients' experiences, and whether any improvement is sustainable.

It would appear from this study that capacity to pay attention to patient feedback within quality improvement is highly variable in practices. Practitioners and teams continually use tacit knowledge of their patients at an individual and organisational level to tailor their work, rather than just respond to the formal feedback they receive. Teams' predictions of their patients' satisfaction with the service appear to be relatively accurate however they appear to be less accurate in their assumptions about patients' willingness and preferences for providing feedback about their care experience. The reliability of the Better Together survey is yet to be reported and further research is needed to examine how teams can be best supported to be more aware of their patients' experiences of care and use such information to continually improve their services.

Research aimed at evaluating improvement programmes that focus on the enhancement of general practice teams' abilities to engage in quality improvement in meaningful and efficient ways may enhance our understanding of how teams can continually consider and improve patients' experiences of care.



## Appendices

### Appendix 1 Historical summary of the increased focus of involving patients in the evaluation of general practice care

Year(s)	Publication	Change intended/occurred	Source
1966	Family doctors charter & GP contract	Allowed reimbursement for employment of staff and practice premises. Some practices started to introduce practice management roles.  Improved pay of GPs.	Spooner (2004)(192)
1983	Royal College of General Practitioners quality initiative	Ensure GPs could describe the services they provided , have objectives for that care and monitor their performance against such objectives	Irvine (1990)(193)
1984	Griffiths report	Highlighted the need for the health service to pay the same level of attention to consumer dimension as their private counterparts	Barnes and Wistow(1993) (26, 194)
1987	Promoting Better Health: the Governments' Programme for Improving Primary Health Care	Public have to come first	Irvine (2001)(89)
1989	Working for Patients (Cmn 555)	Health services would be much more customer orientated	Spooner (2004)(192)
1990	The NHS Act	Health providers had to provide purchasers with details of the range, activity levels, cost and quality of services they could provide. In many cases this included feedback on levels of patient satisfaction.	Brooker DJ & Dinshaw CJ (1998)(195)
1990	"Old" GMS Contract	Ensure claims were robustly administered and systems in practice would ensure meeting of targets.  Introduction of fund holding opportunities.  Some practices chose to fund hold and	Checkland (2004)(196, 197)

		used management allowance within the arrangement to employ a practice manager.	
1995	Good Medical Practice	Written by the GMC, introduce revalidation of doctors as an essential component of protecting the public	Irvine (2001)(89)
First introduced 1996	Quality Practice awards	Practices could voluntarily enrol for practice accreditation and /or quality practice award. Gaining the views of patients is a core standard within each award	RCGP (2014) (198)
1997	Designed to Care	Announced a new patient charter and the need for GPs to work in partnership with community services to provide care	Wright (1998) (199)
1999	Designed to involve: public involvement in the new primary care structures	Aimed to provide guidance on how primary care organisations would involve patients in quality as indicated in Designed to Care. Sets out 3 levels of public involvement- informing, engaging and partnership	Scottish Consumer Council (1999)(200)
2004	New GMS Contract	<p>Introduction of a Quality and Outcomes framework which incentivised a population based disease management programme.</p> <p>Change to how GPs are funded with mix of capitation, fee for service and performance related pay. 1/3 of GP pay linked to quality rather than the previous 4%</p> <p>Incentivised to ask patients their views of services using standard surveys (GPAQ and IPQ) Quality points allocated for involving patients in reviewing survey responses and for survey results reflecting good access to GP appointments.</p> <p>Funding to support GP appraisal made available. GP appraisals require patient survey feedback every 5 years</p>	NHS Employers(2004)(201)
2003	Partnerships for Care	Establishes Scottish Health Councils with a role to monitor Boards involvement of patients and public	NHS Scotland (2003) (202)
2005	Delivering for Health	Shifting the balance of care to primary care and ensuring service are available locally, match people's needs and delivered in ways that support patients	<p>Scottish Government</p> <p><a href="http://www.scotland.gov.uk/">http://www.scotland.gov.uk/</a>(2005)(</p>

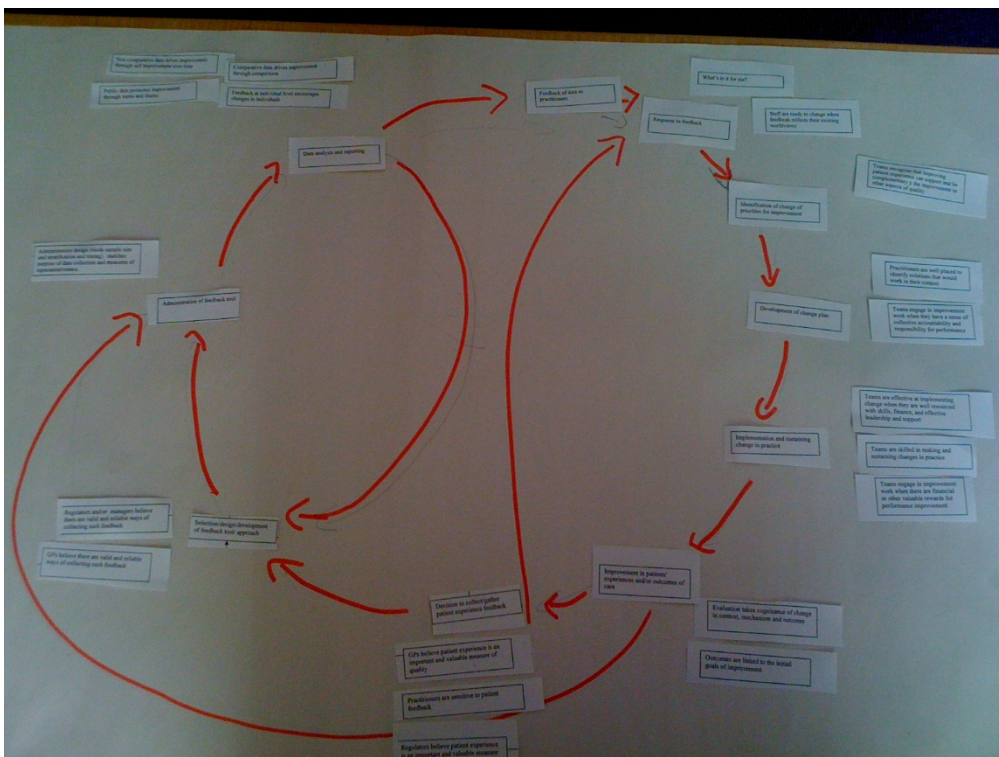
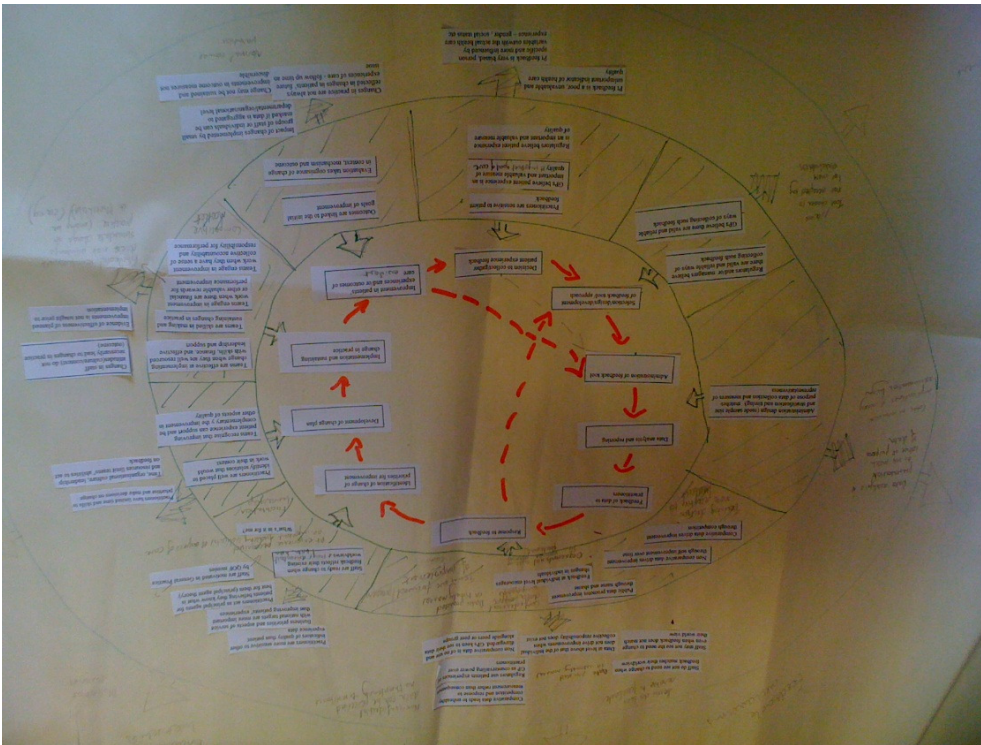
		to be engaged in self-management.	203)
2006	England – enhanced services for access and patient choice	Centrally administered patient survey used to monitor patients’ experience of access to GP practices	NHS Employers(204)
2007	Trust Assurance and Safety?	Although appraisal had been introduced earlier (England 2002, Northern Ireland and Scotland 2003, Wales 2004; this white paper highlights the need for patient feedback to be central to GP revalidation. This is not formalised in practice until 2012	Department of Health (2007) (205)
2007	Local Government and Public Involvement in Health Act	People in communities in England to be involved in commissioning services; people are to be enabled to monitor and review care services; views of people about their needs are to be sought and services must action improvements in care services in response to feedback. Local involvement networks (LINKs) to be established to support public involvement.	UK Government(2007 ) (206)
2007	Direct Enhanced Services Patient survey (England)	To reward practices which provide good access for patients.	Carter et al (2009) (186)
2007	Better Health, Better Care: Action plan	Emphasised development of mutual relationships and cooperation and collaboration between services and between professionals and patients and communities	The Scottish Government (2007)(12)
2008	Direct enhanced services payments	Moved to QOF and Scotland joined in	NHS Employers (2008) (207)
2008	Darzi report – High Quality care for all: NHS next stage review final report	Services to be configured round people’s needs. Evaluations of quality of frontline care will be for the first time published and will include patients’ views on the success of their treatment and the quality of their experiences	Department of Health (2008)(13)
2009	Scotland – GP patient survey – Better	Nationally administered patient experience survey. Access payments in QOF increased from £40m to £68m and payment for access ‘performance’	Carter M (2009) (186)



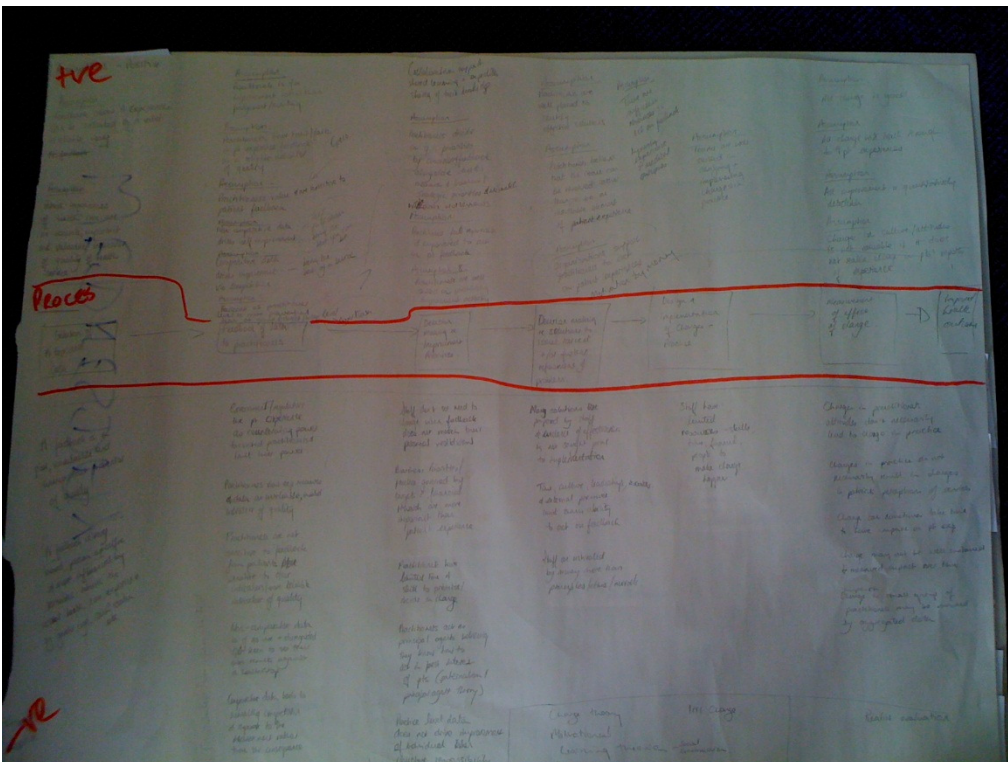
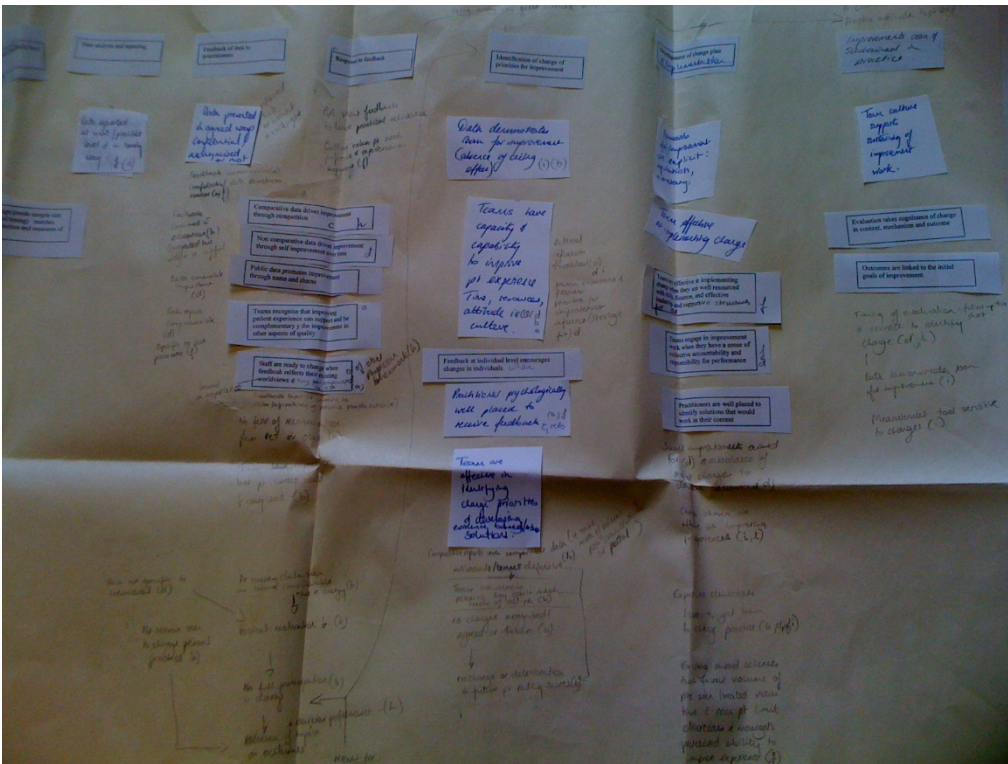
	Together	<p>informed by nationally conducted survey results as opposed to previous practice conducted surveys.</p> <p>Centre for public involvement established in England to encourage patient and public involvement in health and social care</p>	
2010	The Quality Strategy (Scotland)	Patients will have the opportunity to systematically comment on their experience of care and its impact on their quality of life	The Scottish Government <a href="http://www.scotland.gov.uk/">http://www.scotland.gov.uk/</a> (2010)(6)
2010	<p>Delivering Quality in Primary Care</p> <p>National Action Plan/Implementing the Healthcare Quality Strategy for NHSScotland</p>	<p>Ensure contracts best support the delivery of quality care.</p> <p>Continue to improve self- management capacity of patients and using patient feedback to improve services</p>	The Scottish Government (2010) <a href="http://www.scotland.gov.uk/">http://www.scotland.gov.uk/</a> (74)
2011	Commission on the future delivery of public services	Report on how public services need to be shaped. Primary requirement to design services “with and for people and communities”, develop community and individual resilience	The Scottish Government (2011) (16)
2012	GMC Framework for appraisal and revalidation	To assess individuals fitness to continue to practice by reviewing their individual performance using a range of data including feedback from patients about their experience of consultation.	RCGP (2013)(208)
2011/2012	Changes to GMS contract	Removal of points from patient experience scores and onto locally agreed health board targets	NHS Employers (2012)(185)
2011	Patients’ Rights (Scotland) Act	Gives patients the right to provide feedback and health boards the legal responsibility to provide opportunities for patients to be involved in their health and health care and to give their feedback and for that feedback to be used to improve services	The Scottish Government (2011)(17)



## Appendix 2 Stages of programme theory development







### Appendix 3 Summary of study characteristics and outcomes

Reference	Study type	Study focus, country and setting	Study characteristics	Change in patient experience scores	Practice changes in response to feedback	Issues reported by researchers or identified by review as possibly affecting the influence of feedback	Quality
Greco et al 2004 (150)	Non controlled before and after study	<p>Improvement in patients experiences after use of the Improving Practice Questionnaire (IPQ).</p> <p><b>Context</b></p> <p>42 practices volunteered to take part in study. 12 undertook follow up surveys.</p> <p>Survey combined evaluations of practitioner and practice</p>	<p><b>Patient experience measure(s)</b></p> <p>Improving practice questionnaire (IPQ)</p> <p><b>Method of feedback</b></p> <p>Written practice report-benchmark scores, graphs and qualitative comments. Facilitated Practice meeting –to clarify the results, encourage implementation of small changes and participation in follow up survey</p> <p><b>Outcomes measured</b></p>	<p><b>No statistical improvement</b></p> <p>Most practices (8/12) had higher scores after using the IPQ, but no statistically significant overall improvement.</p>	<p>Staff in some practices were willing to further engage with patients to discuss their results and devise solutions together.</p> <p>Staff reported improvement efforts e.g. appointment system reviews, patient newsletters, reorganisation of practice information</p>	<p>Concerted efforts by practice staff are needed to target specific areas for improvement.</p> <p>Data validity was not questioned.</p>	<p>No information to indicate how participating practices were recruited.</p> <p>Validated survey used but no information relating to survey administration included.</p> <p>Intervention varied between practices, some receiving external facilitation in a</p>

		<p>performance</p> <p><b>Country</b></p> <p>UK</p>	IPQ scores		<p>systems, updating of waiting room facilities and “away days” for teams to discuss the results.</p> <p>Some teams took time together to discuss results (away days)</p>		<p>quality meeting focused on feedback while others not.</p> <p>Results not analysed to examine influence of difference in intervention.</p> <p>Statistical methods consistent with research questions. 5447 patient surveys included in analysis.</p> <p>No information relating to qualitative aspect of study: no participant characteristics; no recruitment information, interview guides or description of</p>
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							analysis.
Vingerhoets et al (2001)(153)	RCT	<p>Impact of feedback of patients' evaluations of care using the Chronically Ill Patients Evaluate General practicesurvey (CEP) to general practitioners on future patients' evaluations of care</p> <p><b>Context</b></p> <p>Acting on feedback was voluntary. Survey combined evaluations of practitioner and practice performance.</p> <p>Training practices were over represented compared to national average and GPs were predominantly</p>	<p><b>Patient experience measure(s)</b></p> <p>Chronically Ill Patients Evaluate General practice survey (CEP)</p> <p><b>Method of feedback</b></p> <p>Individual GP's scores against study population scores. Abstract of systematic review on determinants of patients' evaluations of care and short instruction manual on how to interpret and respond to feedback results</p> <p><b>Outcomes measured</b></p> <p>CEP scores</p>	<p><b>No statistical improvement (in intervention group)</b></p> <p>Patient evaluations of medical care increased by 0.09 in the control group and only by 0.01 in intervention group (p=0.0305).</p> <p>Patients' evaluations of continuity were less positive in the intervention than the control group after the intervention (p=0.0236)</p> <p>No differences were found in</p>	Many GPs reported changes in their professional performance	<p>GPs views of the value of formal patient feedback became increasingly sceptical once exposed to it.</p> <p>GPs received results anonymously as requested</p> <p>GPs reported finding it difficult to make changes to their practice.</p>	<p>Systematic , stratified recruitment of GPs to reflect the national urban and rural situation.</p> <p>GPs randomly selected to intervention or control groups after being matched for practice size.</p> <p>Validated survey used.</p> <p>GPs administered surveys to consecutive patients but adherence to "consecutive" not assessed.</p> <p>Process of data collection</p>

		<p>male (84%)</p> <p><b>Country</b></p> <p>Netherlands</p>		<p>remaining seven dimensions of patient experience</p> <p>Patients' evaluations did not change even when GPs reported actions in response to feedback.</p>			<p>explicit e.g. written surveys to GPs to seek biographical and practice data and changes made in response to feedback. Potential for bias in responses e.g. GPs reporting change when it had not taken place.</p> <p>Intervention consistently applied.</p> <p>Multiple regression analysis was consistent with research question and tested for influence of practice, intervention and</p>
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							<p>conditional intervention effects.</p> <p>Small drop out rates (5/63; only 1 from intervention group). Drop out characteristics no different to others.</p> <p>Conclusions consistent with key findings.</p>
Tam (2007)(155)	Uncontrolled before and after study	<p>Change in patient satisfaction scores following significant redesign of services</p> <p><b>Context</b></p> <p>University primary health care team who had committed to improving service and facilities prior</p>	<p><b>Patient experience measure(s)</b></p> <p>Bespoke patient satisfaction survey</p> <p><b>Method of feedback</b></p> <p>Provided to quality improvement team. Specific mode not reported</p> <p><b>Outcomes measured</b></p>	<p><b>Some statistical improvements</b></p> <p>8 out of 15 patient satisfaction measures improved. No change in one measure; 3 were non-statistically better and three were non-</p>	<p><b>Feedback informed improvements</b></p> <p>Results provided input for quality improvement measures, a range of which were instituted during 2004.</p> <p>Increased</p>	<p>Clinical team and management had committed to significant re-design of service prior to gathering patient feedback and gathered own patient feedback.</p>	<p>Convenience sample used.</p> <p>Practice already accredited for having high standards of care.</p> <p>Bespoke and unvalidated patient satisfaction survey tool that</p>

		to seeking feedback  <b>Country</b> Hong Kong	Patient satisfaction and patient utilisation rates  .	statistically worse in follow up scores.	utilisation of the service by patients.		used single item scales for a number of aspects of service.  Surveys were conducted by interviewers who were senior students at the university with limited training in survey administration. Authors indicate quality of fieldwork was closely monitored but fail to provide details.  Patients were identified by those independent to the clinical team and at 10 minute intervals to limit personal
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							<p>judgements on selection.</p> <p>Practice characteristics significantly changed following “before” data.</p> <p>Aggregate scores only were used, no analysis for influence of individual practitioners.</p>
Carey R.G. (2002)(156)	Quality improvement report	<p>Impact of providing patient feedback combined with financial incentive to clinical teams using a physician office visit survey</p> <p><b>Context</b></p> <p>Financial incentives rewarded when department scores increased above collectively agreed</p>	<p><b>Patient experience measure(s)</b></p> <p>Physician office visit survey (Seibert et al 19996)</p> <p><b>Method of feedback</b></p> <p>Feedback to departments of comparative results; run charts with mean scores plotted against mean for all sites.</p> <p><b>Outcomes measured</b></p>	<p><b>Mixed</b></p> <p>One team demonstrated improvement, the other did not.</p>	Nil reported	<p>Financial incentives appeared to drive improvement efforts but not consistently lead to changes in patient experience survey scores.</p> <p>Data supported the identification of specific areas for improvement</p>	<p>Convenience sample.</p> <p>Use of a validated patient survey.</p> <p>Survey administered by mail independent of practitioners.</p> <p>One site</p>

		level <b>Country</b> USA	Physician office visit survey				provided paediatric care but it is unclear if it was children or their parents that were asked to complete the survey.  Analysis did not adjust for baseline performance differences between practices or for other variables that may have influenced experience scores.
Isenberg SF, Stewart MG (1998)(158)	Prospective , multi site, non randomised case control study	Quantitative measurement of effects of quality improvement-based intervention on the improvement in patient satisfaction with physicians'	<b>Patient Experience measure:</b> Visit rating questionnaire (VRQ)  <b>Method of feedback</b> Intervention group received confidential	<b>Mixed</b>  Intervention group achieved small statistically significant in all patient satisfaction summary scores	Nil reported	Assurance of confidentiality of results provided to physicians allayed the suspicions of several of the participants	Convenience sample of medical teams already involved in an improvement collaborative.  Use of well

		<p>office visits</p> <p><b>Context</b></p> <p>Voluntary participants from community based practice physicians in peer-led research</p> <p><b>Country</b></p> <p>USA</p>	<p>ratings benchmarked against their group means <i>and</i> teams displayed a quality improvement poster in employee areas for 30 days</p> <p>Control group received the confidential reports benchmarked against their group means only</p> <p><b>Outcomes measured</b></p> <p>Patient satisfaction survey results (VRQ)</p>	<p>and overall visit scores.</p> <p>Control group did not realise any statistically significant improvements in patient satisfaction scores.</p>		<p>Patient feedback combined with a poster quality improvement poster had a small effect on patient experience survey scores.</p>	<p>recognised and used validated survey tool.</p> <p>Continuous data were collected monthly in addition to before and after data. Patients were randomly selected and surveyed by experienced researchers.</p> <p>Surveys were conducted verbally and therefore did not exclude those with low literacy.</p> <p>Intervention consistent across all teams.</p> <p>Qualitative study methods including data analysis process</p>
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							<p>described in detail.</p> <p>Qualitative evaluation of intervention was conducted by researchers who were separate to those who took part in the delivery of intervention or administration of patient surveys.</p> <p>Interviews used theoretically informed topic guide.</p> <p>Qualitative and quantitative findings are described in detail including quotes.</p> <p>Discussion and conclusions consistent with</p>
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							findings.
Davies et al (2008)(152)	Process evaluation of a quality improvement collaborative	<p>Changes in patient experience and team leaders perceived usefulness and experience of taking part in learning collaborative</p> <p><b>Context</b></p> <p>As detailed in Davies et al (2005) above</p> <p><b>Country</b></p> <p>USA</p>	<p><b>Patient experience measure(s)</b></p> <p>Modified CAHPS</p> <p><b>Method of feedback</b></p> <p>As detailed in Davies et al (2005) above</p> <p><b>Outcomes measured</b></p> <p>Staff views and experiences of use of data</p>	<p><b>Mixed results</b></p> <p>Both positive and negative changes in patient survey results. Changes were not always linked to improvement goals set directly after receiving feedback, and very few were statistically significant.</p>	<p>Varied success in implementing change:</p> <p>2/8 teams did not progress beyond setting improvement goals.</p> <p>6 teams had commenced at least one intervention.</p> <p>4 groups implemented their intervention as planned and 2 reported problems making or monitoring them.</p> <p>Evidence of unintended negative consequences reported in 2 groups.</p>	<p>Changes in practice were reported to have been influenced by:</p> <p>Timeliness of data and time to look at data</p> <p>Accessible presentation of data</p> <p>Data presented in focus charts that highlighted the level of importance of issues to patients.</p> <p>complexity and size of change needed and supported identification of specific practice needing improved.</p> <p>Link between areas for improvement and strategic</p>	As above

						<p>priorities.</p> <p>Presence of organisational change amount of training of staff required</p> <p>Culture of teams</p> <p>Use of interventions that did not require major changes in clinician behaviour.</p> <p>Budgetary limitations , lack of time and high workload cited as barriers</p> <p>Reliability or validity of data was not reported as having been questioned by teams.</p> <p>Data was robustly analysed using relevant reference points and supported the identification of</p>	
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						specific areas for improvement  Teams who used external facilitation made differences to data in positive direction.	
Chanter et al (2005)(151)	Cross sectional survey	Staff reports of the changes they had made or planned to make in response to feedback provided from a patient experience survey (GPAQ).  <b>Context</b>  Practices volunteered to undertake surveys  <b>Country</b>  UK	<b>Patient experience measure(s)</b> General practice Assessment Questionnaire(GPAQ)  <b>Method of feedback</b>  Reports of GPAQ results (practice level data) with template action plan; newsletter summarising scores, comparisons across region, tips on how to achieve higher patient experience scores and information and access to a website to access comparative data for the area.  <b>Outcomes measured</b>  Submission of action plans from practices and	<b>Not measured</b>	Mixed reports of action taken and poor response rate:  Only 44/183 (24%) practices that received survey reports submitted evidence of improvement plans.  Changes in practice planned were varied.  Action plans varied in quality and in the amount of actions planned.	Staff appreciated technical support provided to produce and report the data in timely way.	Convenience sample i.e. one region however all practices took part in study. Sample large – 696 GPs.  Validated survey tool used  Intervention consistent across all practices.  Practice scores not adjusted for demographic variables although this is not of significant importance as

			practice staff evaluations of survey administration service.				<p>there was no quantitative before and after assessment.</p> <p>Impact was evaluated through qualitative means.</p> <p>Qualitative investigation was restricted to self-reporting action plans and therefore lacked sufficient rigour. Only 24% of practices responded to requests and potential responder bias was high. No investigation into non responders' experiences were made.</p>
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Hearnshaw (1996)(149)	Postal survey of primary health care teams	<p>Reports of primary health care teams' patient survey activity, their perceptions of its estimated cost and benefits and their reports of what changes it had stimulated.</p> <p><b>Context</b></p> <p>No specifics noted</p> <p><b>Country</b></p> <p>UK</p>	<p><b>Patient experience measure(s)</b></p> <p>Various (this study involved a survey of practices to identify which patient surveys they were using)</p> <p><b>Method of feedback</b></p> <p>N/A</p> <p><b>Outcomes measured</b></p> <p>Practice reports of changes made in response to patient feedback</p>	Not measured	<p><b>Surveys mostly viewed as beneficial</b></p> <p>44% of GPs responded.</p> <p>Survey costs ranged from £0-£2200</p> <p>61% of those responding reported changes having been made.</p> <p>22% reported planned changes.</p> <p>Most changes were to appointment systems.</p> <p>Perceived benefits included reduction in patient waiting times, increased awareness of patients' views, improved patient comfort, and improved image of the practice.</p>	Teams gathered own feedback.	<p>Non validated survey was sent to all primary care management teams across England.</p> <p>Surveys used to understand impact of patient surveys in each region were piloted but no detail of pilots is provided.</p> <p>Surveys were administered by regional authority staff on behalf of research team but no quality assurance of process built in.</p> <p>Costs incurred by practices when</p>
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					Only 8.2% of GP responders believed the costs to outweigh the benefits of doing patient surveys.		conducting surveys used crude economic methods and self reporting.  Potential for biased responses were high and non responders experiences of using patient surveys were not investigated.  Response rates to surveys enquiring as to the use and impact and costs of undertaking patient surveys was very low.
Wensing M and Elwyn G (2003)(209)	RCT	Impact of feedback of patients' evaluations of care to GPs. Impact measures included video observation	<b>Patient experience measure(s)</b>  Chronically Ill Patients Evaluate General practice (CEP) and observations of	<b>Not reported</b>	No change in quality of GP communication.  Most GPs reported	Negative impact on clinicians' attitudes: towards surveys  All practitioners were highly motivated to learn	Systematic, stratified recruitment of GPs to reflect the national urban and rural

		<p>assessment of GP communication skills, follow up patient feedback scores and GP perceptions and reports of patient feedback and its impact.</p> <p><b>Context</b></p> <p>As reported in Vingerhoets</p> <p><b>Country</b></p> <p>Netherlands</p>	<p>patient consultations</p> <p><b>Method of feedback</b></p> <p>As reported above for Vingerhoets</p> <p><b>Outcomes measured</b></p> <p>CEP, GP reports of use and views of data, repeat observations of consultations</p>		<p>taking some form of action in response to feedback.</p> <p>.</p>	<p>from patients' views before and after intervention but after the intervention fewer in intervention group considered the survey to have practical relevance for their practice than in control group.</p> <p>Compared to the control group, GPs in the intervention group more frequently viewed patient surveys as requiring considerable time and energy, and more frequently saw little reason to change after receipt of feedback</p> <p>Barriers:</p> <p>Key perceived (by clinicians) barriers to changing practice</p>	<p>situation.</p> <p>GPs randomly selected to intervention or control groups after being matched for practice size.</p> <p>GPs taking part in the study were volunteers.</p> <p>Survey used for this aspect of study was unvalidated and there is no detail given to its theoretical foundations. Quality of consultations was however rated independently by two trained raters assessing video observations</p>
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						<p>were difficulty in meeting the needs of all patients; difficulties in interpreting survey results, and difficult to use survey results</p>	<p>using a validated observation tool.</p> <p>Response rate to surveys asking for GPs experiences of using patient survey data was 100%.</p> <p>Methods used for data analysis of qualitative feedback from GPs is not reported but quantitative analysis of observations of consultations is reported.</p>
Davies E. and Cleary P.D. I (2005)(108)	Qualitative exploration of factors affecting use of patient survey data	Interviews with improvement leaders, focusing on their perceptions of how their current involvement in an	<p><b>Patient experience measure(s)</b></p> <p>Modified Consumer Assessment of Healthcare providers and Systems (CAHPS)</p>	Not measured		Staff perceived there would be and had been in the past 3 main barriers to improving patients' experiences:	As reported for Davies previously

		<p>improvement collaborative focused on the use of (CAHPS) score differed to previous efforts to improve patient centredness.</p> <p><b>Context</b></p> <p>Improvement teams led by senior executives who volunteered for the study.</p> <p><b>Country</b></p> <p>USA</p>	<p><b>Method of feedback</b></p> <p>Regular written reports and access to online comparative data. Data provided in 'focus charts' with performance relative to other groups mapped against areas patients find most important.</p> <p>Intense facilitation from improvement leaders individually and within improvement collaborative meetings.</p> <p>Written improvement guide.</p> <p><b>Outcomes measured</b></p> <p>CAHPS scores</p>			<p><b>Organisational:</b></p> <p>Lack of supporting values, competing priorities, lack of quality improvement infrastructure including positive leadership from senior managers and senior physicians along with staff persistence over several years.</p> <p><b>Data:</b></p> <p>Lack of expertise (with data);lack of timely feedback; uncertainty over effectiveness of interventions and rate of change; lack of cost effectiveness and lack of data that pinpointed what needed to change in individual</p>	
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						teams/departments.  <b>Professional:</b>  Clinical scepticism; defensiveness and resistance to change; selection of staff for technical skills rather than people skills; negative feedback promotes an emotive response from some staff.	
Carter et al (2004)(133)	Qualitative evaluation	Practices' experience of receiving feedback from an independent provider of a patient experience survey (IPQ).  <b>Context</b>  Practices volunteered to take part	<b>Patient experience measure(s)</b>  Improving practice questionnaire (IPQ)  <b>Method of feedback</b>  Practice managers received practice level data. GPs received personal results.  <b>Outcomes measured</b>  Practice staff, primary care trust staff and patients' views and	<b>Not measured</b>	<b>Poor response rate of practices</b>  Very small proportion of those taking part in survey engaged in providing feedback to research team on the influence of the patient survey results.  Most practices recognised value of	Mixed reports from staff:  Many questioned validity of tool and methods of administration.  Some thought results only confirmed what they already knew and other sceptical of representativeness of samples.	Sampling method used within some primary care trusts was unclear.  Large number (42) practices took part.  Use of a validated survey tool.  Survey was administered



		<p><b>Country</b></p> <p>UK</p>	<p>experiences of using the data and perceptions of impact</p>		<p>feedback in prioritising actions for improvement</p> <p>Many practices encouraged by positive responses</p> <p>Practices noted that feedback useful for lobbying for additional funding for premises improvements</p> <p>Some practices use individual reflection and multiprofessional discussions in response to feedback, noting the links between personal, professional and team development.</p> <p>.</p>	<p>Ways in which results were communicated in practices varied.</p> <p>Practices noted the need for any changes to be small</p> <p>PCT and practice aims differed- PCTs wanted to use results strategically to identify practices that required improvement, practices wanted to use it for education and development.</p> <p>GPs were concerned that data would be used for performance rather than development</p> <p>Data supported the identification of specific areas for improvement</p> <p>Difficulties were</p>	<p>consecutively by practice staff but consecutive was not independently assessed.</p> <p>Surveys were returned to the practice and not directly to the research team.</p> <p>Intervention not consistent, participation in meeting to discuss patient survey results was voluntary and there was little uptake of this.</p> <p>No investigation into the views or experiences of those who chose to not take part in this element of the</p>
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						<p>found in trying to get this aspect of quality on already full strategic agendas.</p> <p>Teams were provided with external facilitated feedback</p>	<p>intervention was undertaken.</p> <p>Significant limitations in the reporting of methods used in qualitative part of study e.g. no topic guides, no details of numbers or characteristics of participants (GPs, teams or patients).</p> <p>Qualitative data analysis processes used was not reported</p>
Kibbe D et al (1993)	Quality Improvement report	Impact of reviewing complaints, patient feedback and medical record audit of continuity of care.	<p><b>Patient experience measure(s)</b></p> <p>Last 9 months of complaints, audit of practice records(to measure continuity), patient survey</p>	<b>Not measured</b>	<b>Improved continuity</b>	<p>Teams gathered own feedback after identifying that continuity of care was poor.</p> <p>Data supported the identification of specific areas for</p>	<p>Convenience sample of one family practice centre.</p> <p>The process of improvement used for this team is detailed</p>

		<p><b>Context</b></p> <p>Feedback from patients was initiated by the team following the identification of issues associated with continuity of care</p> <p><b>Country</b></p> <p>USA</p>	<p><b>Method of feedback</b></p> <p>Written feedback for whole practice presented to quality improvement team</p> <p><b>Outcomes measured</b></p> <p>Continuity audit of records</p>		reduced.	improvement that reflected team's own assessment of quality.	<p>but methods used to collect this information are not reported.</p> <p>Surveys used to gauge patient experience and staff perceptions were not validated and provided no opportunity to investigate issues in any depth.</p> <p>Administration of patient and staff survey processes are not reported.</p> <p>Audit tools used to assess continuity of patient care were not validated and it is not clear if</p>
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							<p>audits were self assessments or independent to the clinical team.</p> <p>Changes in patient experience were not assessed by independent patient reports but instead by review of patients' records</p>
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## Appendix 4 Participant information sheet

20/10/2014 Participant Information Sheet version 3



### **Research Project: What scope is there to improve the use of feedback about patients' healthcare experiences in General practice?**

#### **Participant Information Sheet**

We invite you to participate in a research project. We believe it to be of potential importance. However, before you decide whether or not you wish to participate, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with outsiders. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

This study seeks to explore how patients' reports of their experience of using GP services are gathered and used by General practice. You are one of a group of General practices in Scotland being asked to take part in the research. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

#### **What is the purpose of the study?**

The aims of the study are to explore how General practices get access to, perceive and make use of feedback from patients about their experience of the practice. It will also explore how such information is used in the practice and the approaches practices take to enhance patients' experiences.

- **Why have I been chosen?**

I am seeking a variety of views from General practice staff and other stakeholders who are involved in gathering, using or receiving patient healthcare experience feedback data and from local patient/public representatives.

- **Do I have to take part?**

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason. If practices have not responded within 4 weeks of the initial invitation letter being sent the researcher will contact them by phone to discuss the practice's potential participation in the study.

- **What will the study involve?**

Case study method will be used to explore the views of and use of feedback about patients' experiences of General practice. I will therefore be seeking to conduct short individual interviews with a range of practitioners within the practice and interviews with patients or members of the public who have engaged with the practice about their experiences. I will also be seeking to observe

practitioners outwith patient consultations and attend any relevant meetings where service developments and /or quality improvements are discussed.

Practice documents that are relevant to the study aims will be analysed e.g. minutes of quality QOF reports /performance reports, communication between General practice and CHPs or others e.g. primary care, management team meetings regarding QOF, waiting room leaflets and posters, patient healthcare feedback tools, patient healthcare feedback results, reports and action plans, service quality reports, complaints /suggestions and reports/responses.

Interviews will take place at your place of work at times suitable to the practice. The interviews will last no more than half an hour and with individual consent, will be recorded so that nothing important is missed.

- **What are the possible benefits of taking part?**

As feedback from patients about their experience of health services increases in importance it is crucial that we understand how useful this type of quality data is and if and how it can be used to improve future patients' experiences.

- **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers and pseudonyms, and you or your practice name will not be used. No information about any single individual or organisation will be available to any other person apart from the researcher and her academic supervisor. Five years after the research is completed and reported, all the transcripts and digital recordings of interviews will be destroyed.

- **What will happen to the results of the study?**

Findings from the study will be shared with the Chief Scientist Office (CSO). Opportunities will also be sought to publish in academic journals and present at relevant conferences and seminars. I can if requested, provide your practice with a short summary report of the findings from your practice.

- **Who is organising and funding the research?**

The study has been funded by the Chief Scientist Office which is funded by the Scottish Government.

- **Who has reviewed the study?**

The Tayside Committee on Medical Research Ethics, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research be made available for scrutiny by monitors from the University of Dundee and NHS Tayside, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

- **Who can I make a complaint about the study to?**

You can make a complaint about the study to:

**Professor Vikki Entwistle**

Social Dimensions of Health Institute

Universities of Dundee and St Andrews

11 Airlie place

Dundee

DD1 4HJ

01382 388658/Email: [v.entwistle@cpse.dundee.ac.uk](mailto:v.entwistle@cpse.dundee.ac.uk)

Thank you for reading this information. Please do not hesitate to contact me for further information regarding the study.

**Deborah Baldie**

Clinical Research Fellow

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## Appendix 5 Staff consent form

Staff consent form version 2



### CONSENT FORM

**Title of Project:** What scope is there to improve the use of feedback about patients' healthcare experiences in General practice?

Name of Researcher: Deborah Baldie

**Please initial each box**

1. I confirm that I have read, and that I understand, the Participant Information Sheet version 3 dated 21/10/2010. I have had opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the interview, without giving any reason.	
3. I consent to being observed by the researcher outwith patient consultations.	
4. I consent to taking part in a face to face interview with the researcher. 5. I consent to the face to face interview with the researcher being audio taped. 4. I understand that any quotations or other results used in writing up the study findings will not be identifiably attributed to me or the practice and I agree to the inclusion of quotations or other results in reports about the study	

**I agree to take part in the study.**

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature



## Appendix 6 Patient recruitment poster



### Research Study: How is patient experience feedback used within General Practice?



Have you ever given or considered giving feedback about your experience of using the practice?



Would you be willing to spend a little time discussing with a researcher what your experience of using the service is like and how the practice should seek and use the your views?

The practice is currently taking part in a study exploring how we get feedback about patients' experiences of the practice and how it uses this information.

**If you would like to take part in an interview or hear more about the study please contact the researcher directly:**

**Researcher:**

Mrs Deborah Baldie

Address Social Dimensions of Health Institute  
Universities of Dundee and St Andrews,  
11 Airlie Place, Dundee, DD1 4HJ,  
Telephone: **01382 385725**  
Email: [d.baldie@dundee.ac.uk](mailto:d.baldie@dundee.ac.uk)

## Appendix 7 GP staff script for approaching patients

### Patient/Public recruitment telephone call guidance

**Project title:**

**What scope is there to improve the use of feedback about patients' healthcare experiences in General practice?**

Hello it is [name]..... from your GP. The practice is currently taking part in a research study about how we get to hear about patients' experiences of using the practice and what they do with this information.

The researcher is based within the University of Dundee and is looking to speak with patients or members of the public that **have recently booked an appointment with the practice** so she can explore **their experiences of using the practice and their views of how the practice does/should seek their feedback about the service they receive.**

Would you be willing for the researcher to contact you to explain the project a little more to you and explore if you would be willing to take part in a short interview?

**Patient name:**

**Patient contact details:**

**Address**

## Appendix 8 Patient Information sheet

03/09/2010 Participant Information Sheet Version 2 – patients/public

### **Research Project: What scope is there to improve the use of feedback about patients' healthcare experiences in General practice?**

#### **Participant Information Sheet**

We invite you to participate in a research project. We believe it to be of potential importance. However, before you decide whether or not you wish to participate, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with outsiders. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

This study seeks to explore how patients' reports of their experience of using GP services are gathered and used by General practice. You are one of a group of people who have given feedback to the practice recently and are being asked to consider taking part in this research. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

- **What is the purpose of the study?**

The aims of the study are to explore how General practices get access to, perceive and make use of feedback from patients about their experience of the practice. It will also explore how such information is used in the practice and the approaches practices take to enhance patients' experiences.

- **Why have I been chosen?**

I am seeking a variety of views from General practice staff and other individuals who are involved in gathering, using, receiving or providing feedback about patients' experiences of the practice. In particular I am seeking interviews with patients or others speaking on behalf of patient[s] who have previously provided feedback to the practice about their experiences of using the GP services.

- **Do I have to take part?**

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting your future medical care or your relationship with medical staff looking after you.

- **What will the study involve?**

I am seeking to conduct a short [45 mins to an hour] focus group interview with patients or members of the public who have engaged with the practice about their experiences. Interviews will take place at the GP practice or the University of Dundee at a mutually convenient time. With individual, informed consent, the interview will be recorded so that nothing important is missed.

- **What are the possible benefits of taking part?**

As feedback from patients about their experience of health services increases in importance it is crucial that we understand how useful this type of quality data is and if and how it can be used to improve future patients' experiences.

- **Will my taking part in this study be kept confidential?**

The information that you provide is strictly anonymous and confidential. The information will be stored using study numbers and pseudonyms, and you or your practice name will not be used. No information about any single individual or organisation will be available to any other person apart from the researcher and her academic supervisor. Five years after the research is completed and reported, all the transcripts and digital recordings of interviews will be destroyed.

- **What will happen to the results of the study?**

Findings from the study will be shared with the Chief Scientist Office (CSO). Opportunities will also be sought to publish in academic journals and present at relevant conferences and seminars. I can if requested, provide your practice with a short summary report of the findings from your practice.

- **Who is organising and funding the research?**

The study has been funded by the Chief Scientist Office which is funded by the Scottish Government.

- **Who has reviewed the study?**

The Tayside Committee on Medical Research Ethics, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has examined the proposal and has raised no objections from the point of view of medical ethics. It is a requirement that your records in this research be made available for scrutiny by monitors from the University of Dundee and NHS Tayside, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

- **Who can I make a complaint about the study to?**

You can make a complaint about the study to:

Professor Vikki Entwistle

Social Dimensions of Health Institute

Universities of Dundee and St Andrews

11 Airlie place

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01382 388658/Email: v.entwistle@cpse.dundee.ac.uk

Thank you for reading this information. Please do not hesitate to contact me for further information regarding the study.

Deborah Baldie

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## Appendix 9 Patient consent form

Patient consent form 21/12/2010

### CONSENT FORM

**Title of Project:**

**What scope is there to improve the use of feedback about patients' healthcare experiences in General practice?**

Name of Researcher: Deborah Baldie

**Please initial each box**

1. I confirm that I have read, and that I understand, the Participant Information Sheet version 2 dated 21/10/2010. I have had opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the interview, without giving any reason.	
3. I consent to the focus group interview.	
4. I consent to the focus group interview being audio-taped	
4. I understand that any quotations or other results used in writing up the study findings will not be identifiably attributed to me, and I agree to the inclusion of quotations or other results in reports about the study	

**I agree to be interviewed as part of this study.**

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Researcher

Date

Signature

## Appendix 10 Staff interview topic guide

1. **Just to start with then, what types of information relating to patients' experiences of using the practice services do you or the practice get access to?**
  - service and patient initiated information
  - Types of ways its collected - Surveys/comments cards/focus groups/complaints
  
2. **Perceptions of the ways in which patients' experiences of using the service are sought or provided**
  - What do you think about the ways in which the service gathers or get access to information from patients about their health care experience?
  - How does what you do now compare to previous approaches e.g. What do you think about the Better Together survey compared with the GPAQ/GPAS or IPQ (benefits/ disadvantages) and how do surveys compare with other sources of information relating to patients' experiences
  
3. **Practitioners' views of patient experience feedback data**
  - What do you think about the information that data gathering tools/approaches generate
  - Validity/ reliability /helpfulness/useful and to who?
  - Ways in which data are presented and disseminated
  - Frequency/timeliness of seeking patient experience feedback
  
4. **Practitioners' views of the structures, processes and mechanisms that are aimed to facilitate them to hear about and consider patients' experiences of service use**
  - Tell me what patients are saying or have said about your service up to and including the last year?
  - What were the key issues raised by patients?
  - How do you get to hear about the results of patient experience feedback data?
  - In what ways are the results and /or resulting actions shared with practitioners and patients?
  - Who is the information shared with apart from practitioners and patients?
  - What are your thoughts about how the results are shared and discussed?
  - What ways of sharing and discussing the information are/ would be helpful to you as an individual and why?
  
5. **The perceived impact of and benefits or otherwise gathering/ listening/receiving information about patients' experiences of using the service**
  - What difference do you think gathering and receiving information from patients about their healthcare experience has had on you, your practice, the practice of others and the practice as a whole?
  - Ask for examples

**6. The issues that have enhanced or inhibited practitioners' ability to act on feedback from patients about their service.**

- Tell me about how you and your colleagues go about considering and acting on information given by patients about their health care experience
- Barriers, facilitators

**7. Practitioners' perceptions of how the gathering and use of patients' healthcare experiences can best support improvement of services in the future**

- What do you think would improve the way in which this type of information is used to inform service development?
- What are the approaches you think are most helpful in stimulating practice change in relation to enhancing patient experience?
- What are the things that should be avoided that in your view minimise the opportunities to use this information within your service?



## Appendix 11 Patient interview topic guide

1. **Can you tell me a little about what it is like to be a patient here at ..... Practice – what is the service like?**
2. **Have you ever (without being previously asked), given any of the staff in the practice (including GPs) feedback e.g. verbal thanks, raised your concerns, complaints**
  - If yes, would you mind sharing what that was about and what it was like?
  - If no – are there any particular reasons why this is the case?
3. **Have you ever been asked for feedback on the quality of service you have received at ..... (if no go to question 3)**
  - In what ways have you been asked to or provided the practice with feedback about your experiences of using their service?(**who asked, mode**)
  - What was that like for you? (Easy to do, difficult, helpful, stressful?)
  - What do you think about the questions you are asked? – relevancy/importance
  - What do you think about the ways in which you have been/are encouraged/requested to provide feedback about your health care experience?
4. **In what (other) ways do you think/know the practice seeks or gets to hear about patients' experiences of using the service?**
  - e.g. Surveys/comments cards/focus groups/complaints
5. **What do you think of the ways in which this is done currently?**
6. **How important is it for you to be asked for your feedback?**
7. **How would you prefer to provide your feedback to the practice?**
8. **Views of how patient experience feedback data are shared with the practice population?**
  - Have you ever seen or heard any of the feedback the practice has received from patients e.g. feedback reports, survey reports, presentations etc?
  - If so can you tell me what patients tend to say about the practice and how you got/get to hear about them?
  - If not, how important is it to you that you get to hear about what other patients are saying about the practice? (if important; explore why e.g. what do they use that information for?)
9. **The perceived impact of and benefits or otherwise gathering/ listening/receiving feedback from patients**

What difference do you think gathering and receiving feedback from patients has had on:

Individuals working in the practice

The practice as a whole

Quality of service and

The practice's relationship with its patients

The practice's relationship with you

(Look for examples of specific changes)

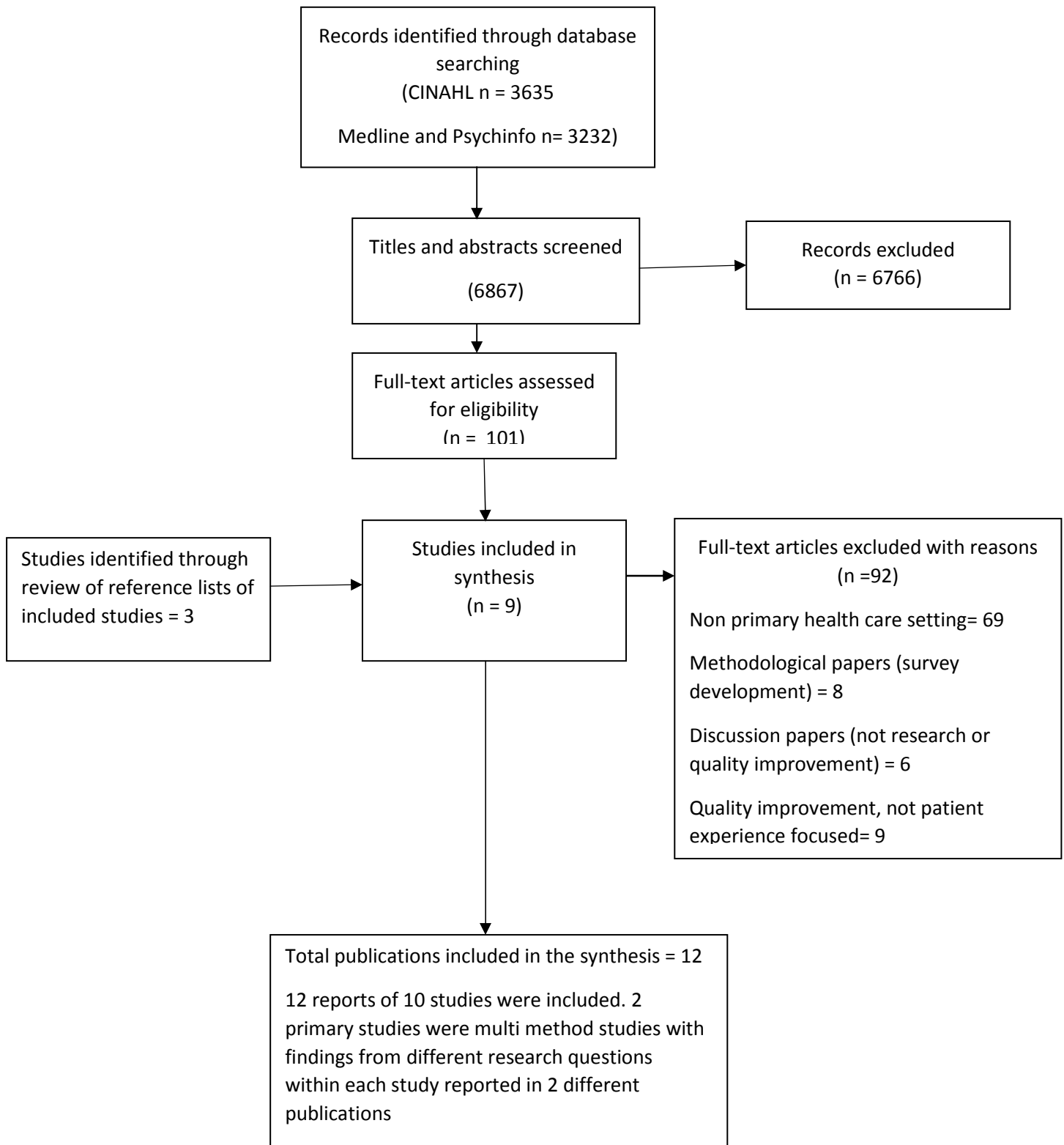
**10. The issues that have enhanced or inhibited people's ability to act on feedback from patients about their service.**

- Are there any specific reasons why you think the practice has or has not changed things in response to what patients have been saying? (If yes – explore further)
- What factors/situations do you think assist or hinder this practice to act on the patient experience data?
- Are there things that you think should be different in the practice- if yes explore what and if they have raised that previously and how was that responded to?

**11. Patient/public perceptions of how the gathering and use of feedback can best support improvement of services in the future**

- Do you think would improve the way in which this type of information is used to inform how the practice operates?

## Appendix 12 Literature Review Summary



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